Addressing the Health Workforce Crisis

A Toolkit for Health Professional Advocates

Created by the Health Workforce Advocacy Initiative
The Health Workforce Advocacy Initiative

The Health Workforce Advocacy Initiative (HWAI) is the civil-society led advocacy network of the Global Health Workforce Alliance (GHWA). HWAI’s purpose is to advocate for the policies and sustained investments necessary to develop and empower a health workforce capable of delivering on health goals. HWAI operates with the firm conviction that everyone has the right to the highest attainable standard of health and that an effective health workforce is central to fulfilling this right. It’s against this background that every effort is needed to make this right a reality for all, whether health care service providers or receivers.

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Introduction

This toolkit was created by the Health Workforce Advocacy Initiative, the civil society-led network of the Global Health Workforce Alliance. The purpose of this toolkit is to assist health professionals, health professional associations, and civil society organizations to develop advocacy strategies to address human resource and health financing issues in their countries.

Health workers play a myriad of roles in the community. They are healers, counselors and leaders. They interact with all members of the community, from children to the elderly. As such, health workers possess a unique opportunity to be powerful and effective advocates for change that will benefit the communities they serve, ranging from increasing the availability of treatment, to improving the quality of the health facility, to improving the conditions within which health consumers seek care and within which health workers provide it.

Critically, the quantity and quality of health professionals throughout the country has an immediate and drastic effect on the quality of care provided to communities. Doctors, nurses, clinicians and other health professionals in sub-Saharan Africa are on the frontline of the struggle to address a massive shortage of health workers and to improve the quality of care for millions. Health workers are in a powerful position: they understand the complexities of the health workforce shortage, and know what it will take to make real progress.

Purpose of this toolkit

This toolkit is designed to assist you as health professionals and civil society organizations to translate that firsthand knowledge into an effective advocacy strategy. Each of the following eight sections outlines a key step in using your experience and knowledge to influence health workforce policies in your country, and to improve your ability to provide essential care and the community’s ability to access it.

Although this toolkit is arranged in eight sections, which correspond to eight basic steps in developing an advocacy strategy, the actual process of developing an advocacy strategy is rarely linear. This toolkit is meant to be a basic guide, but it is okay to move back and forth between sections and steps as needed to meet your needs.

Because the policy and advocacy environment in each country or region is different, this toolkit contains flexible and adaptable tools that coalitions can use to develop their own targeted strategies, and to affect the change most needed in your place of work and your country. The information in this toolkit provides a general background and adaptable tools and techniques—it is up to you to put this toolkit into action, identifying your country’s needs, your solutions, and how to make them happen.

In this toolkit, you will find background information on advocacy and the health workforce that should be helpful as you plan your advocacy campaign. The toolkit is organized into chapters that correspond to the process a coalition might follow in developing an advocacy campaign. Each section has basic explanations of key advocacy considerations as well as sample worksheets and background documents that can be used by coalitions to support the planning process.
What is Advocacy?

There are many definitions of advocacy and many contexts in which advocacy can be used, but this toolkit is specifically concerned with influencing policy changes. In this context, we define advocacy as "an action directed at changing the policies, positions or programs of any type of institution." Advocacy is about identifying a problem, identifying a solution to that problem, and then building the support you need to see your solution implemented.

There is a range of approaches to advocacy, some of which are confrontational, while others involve collaboration, education, outreach, meetings and more collegial approaches to changing power and policy dynamics. Some advocacy groups put these different approaches into a kind of “change continuum:"

Cooperate – Educate – Persuade – Litigate – Contest

This continuum captures a whole array of strategies and tactics advocates can use to make change. Importantly, advocacy follows the entire spectrum; however, individual advocates and advocacy groups do not necessarily have to use all these strategies. For many, the right hand of the spectrum—contesting—is the definition of “activism;” outsider action meant to contest, demand and protest. When people hear the word “activism,” they often imagine violent street marches and protests, and as a result choose not to become involved.

However, health workers often work for governments and have a level of expertise and access that lends itself to cooperation, education and persuasion, as opposed to contestation. At other times, health workers have chosen to go on strike and take more radical action to reach their goals. It all depends on you, your issues, your country, and your campaign. You must find your spot in the continuum and stay flexible as campaigns and challenges change and evolve. The most important thing is to lend your voice, your expertise, and your passion to making change—that is the essence of advocacy.
Defining the Problem: The Global Health Workforce Crisis

The first step in developing a strong advocacy strategy, or advocacy campaign, is to clearly define the problem you need to address. This section provides some background information about the global health workforce crisis. It will help you understand the broad scope of the health workforce crisis and some of the promises and commitments made at international and regional levels, but you will need to do your own research to understand the specific nature of the health workforce situation in your own country. To help you, this section includes some questions that will guide you towards identifying the specific needs of your country.

1.1 The Global Overview

Globally, the health workforce crisis is not a new phenomenon. Health workers have a true understanding that the health workforce in many countries is facing a crisis, including severe shortages of and inequitable distribution of health workers, and that this has a large and negative impact on people’s health, leading to preventable death and suffering.

This comes at a time when countries have committed to important health goals including universal access to HIV services by 2010 and the Millennium Development Goals, which include reducing maternal mortality by three-quarters and child mortality by two-thirds by 2015, compared to 1990, as well as reversing AIDS, malaria, and other major diseases. African countries have committed to universal access to an essential package of health services by 2015. These goals will be difficult—if not impossible—to meet unless we are able to address the current shortages and inequitable distribution of health workers.

In 2006, the World Health Organization provided basic data outlining the extent of the shortage of health workers, which includes a shortage of more than 4.2 million health workers in the 57 countries facing the most severe deficits.

<table>
<thead>
<tr>
<th>WHO region</th>
<th>Number of countries</th>
<th>In countries with shortages</th>
<th>Total number of doctors, nurses, and midwives</th>
<th>Estimated shortage</th>
<th>Percent increase required</th>
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</thead>
<tbody>
<tr>
<td>Africa</td>
<td>46</td>
<td>36</td>
<td>590,198</td>
<td>817,992</td>
<td>139</td>
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<tr>
<td>Americas</td>
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<td>5</td>
<td>93,603</td>
<td>37,886</td>
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<td>South-East Asia</td>
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<td>2,332,054</td>
<td>1,164,001</td>
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<td>Europe</td>
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<td>0</td>
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<tr>
<td>Eastern Mediterranean</td>
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<td>312,613</td>
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<tr>
<td>Western Pacific</td>
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<td>27,260</td>
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<td>World</td>
<td>192</td>
<td>57</td>
<td>3,355,728</td>
<td>2,358,470</td>
<td>70</td>
</tr>
</tbody>
</table>

The crisis is most severe in sub-Saharan Africa, where a mere 3% of the world’s health workers struggle to combat 24% of the global disease burden. 

Beyond the numbers
The health workforce crisis is about more than numbers. Other obstacles to the delivery of quality health services include:

- Severe internal inequities in health workforce distribution, with rural areas being particularly underserved;
- Failure to update health workers’ skills and knowledge;
- Poor management and lack of regular, supportive supervision;
- Lack of essential medicines and supplies required to provide health services;
- Lack of key skills such as human resource management, financial management, and program management;
- Unfavorable policies that restrict nurses and mid-level workers from assuming greater responsibility;
- Inadequate support for community-level health workers and caregivers; and
- Inadequate participation by stakeholders on policy issues that impact health.

Indeed, the inequitable distribution of health workers greatly exacerbates the shortage, as some areas have far fewer health workers than even the national average.

Causes of health worker shortage
Causes of the shortage vary by country, but in general include:

- Massive underfunding of the health sector, in part caused by the structural adjustment policies of the 1980s and 1990s of the International Monetary Fund (IMF) and the resulting cuts and freezes on health spending, has led to inadequate funds to pay health workers living wages and ensure conditions where health workers can perform their jobs effectively. Many countries have also so far failed to live up to their commitments to increase health spending, and development assistance remains far short of need and is rarely targeted at strengthening the health workforce, beyond in-service training.

- HIV/AIDS is taking a major toll on the health workforce, both through death and illness of the health workers themselves and the enormous stress that AIDS places on health systems. Fear of contracting HIV is an obstacle to recruiting and retaining health workers, while the same fear contributes to stigma and discrimination against patients perceived to have HIV/AIDS.

- Many countries lack sufficient training capacity to produce an adequate health workforce.

- Developing countries struggle to retain health workers. In large part due to unsatisfactory conditions caused by lack of funding of the health workforce and health sector, many health workers move to the private sector (often inaccessible to much of the population), to urban areas, or out of the country entirely in search of higher wages and better working conditions. Sub-Saharan Africa loses about 28% of its doctors and 11% of its nurses due to cross-border “brain drain.”

Impact
A shortage of health workers has a major impact on a country’s ability to meet many key development and health goals.

- **Millennium Development Goals:** WHO has identified 57 countries, including 38 in Africa, where the health-related Millennium Development Goals, which focus on maternal and child health, HIV/AIDS, malaria, and other diseases, are “very unlikely” to be achieved with the current number of health workers.

- **Universal access to HIV/AIDS services:** In many countries, universal access to AIDS treatment, prevention, and care simply cannot be achieved without an expanded and equipped health workforce. The
World Bank and WHO have called weak health systems, especially the health workforce crisis, the largest obstacle to universal access, especially for treatment.  

**Maternal health:** In sub-Saharan Africa, a woman’s lifetime risk of maternal death is 1 in 16, compared to 1 in 2,800 in developed countries. According to WHO, “Putting in place the health workforce needed for scaling up maternal, newborn and child health services towards universal access is the first and most pressing task.” A *Lancet* article authored by officials at WHO and other institutions found that “the evidence from many developing countries with massive deprivation where maternal mortality is high suggests that the sheer absence of staff and facilities is the most substantial barrier to progress.”

**Tuberculosis:** In 2003, 17 of the 22 countries with the most severe tuberculosis burdens “reported that their efforts to reach the 2005 targets are being hampered by staffing problems.”

**Immunizations:** The Global Alliance for Vaccines and Immunization (GAVI) has reported, “Measles immunization coverage tends to be high when staffing ratios are good, and low when staffing ratios are poor.” Most countries that do not have at least 150 qualified health workers per 100,000 population fail to achieve 80% coverage for measles immunizations, whereas the vast majority of countries with at least 200 qualified health workers per 100,000 population do achieve this coverage.

**Key recommendations and commitments**

The international community has made several recommendations and commitments regarding health workforce shortages, which are summarized below. Individual countries have also made their own commitments, which you should explore when developing country-specific campaign.

**Numbers:** Estimates vary of the numbers of health workers needed to offer essential health services and to achieve the Millennium Development Goals and other national and international health goals. The World Health Organization (WHO) estimated that 2.28 doctors, nurses, and midwives per 1000 persons, and a total of 4.1 health workers per 1,000 people, are needed to ensure a minimal level of essential health services. At this rate, Africa would need more than 800,000 additional doctors, nurses, and midwives, and a total of nearly 1.5 million additional health workers. In its 2004 study, the Joint Learning Initiative (JLI) similarly estimated that 2.5 doctors, nurses, and midwives per 1,000 persons would be necessary to ensure coverage of 80% for measles immunizations or skilled birth attendants at deliveries.

**Distribution:** Many countries suffer from an uneven distribution of health workers, with a high concentration of workers in urban areas and acute shortages in rural areas. The need to ensure an equitable distribution of health care workers in rural and hard-to-reach areas has led the HWAI to recommend, as a general rule, deployment of 70% of new health workers to such areas. The right to the highest attainable standard of health obligates countries to ensure equitable distribution of health services, goods, and facilities, which also requires an equitable distribution of health workers.

**Skills mix:** Neither the WHO nor other international bodies have prescribed a particular skill mix to ensure the highest quality health services. However, some experts have urged countries to expand the spectrum of health workers to include cadres of mid-level health professionals. For example, the McKinsey Group highlighted the limitations of the classic training model to fill close delivery gaps in rural areas and recommended investing in paraprofessionals and community health workers.

**Financing:** Many African nations committed to increasing health expenditures to at least 15% of overall government budgets in the 2001 Abuja Declaration. The JLI Africa Working Group estimated that human resources account for 55-75% of recurrent expenditures in health sector budgets. In its 2001 report, the WHO Commission on Macroeconomics and Health calculated the cost of a minimum package of essential health services at $34 per capita by 2007, rising to $38 by 2015. Separately, the World Health
Organization’s World Health Report 2006 estimated that the minimum per capita spending required for scaling up the health workforce is $10 per person. These combined figures suggest that the minimum per capita health spending will likely have to be approximately US$44-48 per capita.19

Ghana
Ghana sought to address its health workforce shortage by producing cadres of mid-level workers or paraprofessionals. In 1999, the government began training and deploying Community Health Officers, nurses with approximately two years’ training, for service in rural communities. By the end of 2004, Ghana had trained 310 of these Community Health Officers, who were helping to bring care to nearly 1 million people. One district saw its childhood immunization rate triple, maternal and child mortality fall significantly and the rate of tuberculosis defaulters drop from 73% to 0%.20

1.2 Defining the HRH Problem in Your Country
Each country has its own context and its own human resource for health challenges to address. Part of developing an effective strategy is understanding the context in your country. Finding answers to the questions below should help you define the specific challenges that need to be addressed in your advocacy strategy.

- What are the major causes of health worker attrition in your country? What is being done to address these factors? What else can be done to address them?
- Are incentive packages in place to retain health workers, especially in rural areas?
- Are working conditions safe? If not, what is the government doing to address this?
- Do health facilities have a regular supply of medicines and equipment? If not, what is being done to address this?
- Are health services, including confidential HIV services, available to health workers?
- Are students being recruited from rural areas for health professional training?
- Is the health worker recruitment process perceived as being fair and transparent?
- Do health workers have adequate opportunities for professional development and career progression? If not, how might this be improved?
- Are community health workers and “mid-level” health workers such as clinical officers being used to help fill skills gaps and address shortages, especially in rural areas?
- Do faith-based and private health facilities face the same challenges as public health facilities?
- Are there other programmes designed to improve and develop the health workforce that are being implemented by international donors? Are they streamlined within the Ministry of Health in your country? If not, what effect is that having on health workers in the public sector?

Once you have answered these questions and understand the scope of the problem, you are ready to develop specific goals and objectives to help you advocate for a solution to the health workforce crisis in your country.
Set Campaign Goals and Objectives

One of the most important, but also most difficult aspects of developing an advocacy campaign is setting clear and strong goals and objectives. Coming to consensus on the goal and objectives can take a considerable amount of time and effort, especially when you are trying to address a broad and complicated issue like the health workforce.

Section one dealt with defining the problems relevant to the health workforce crisis globally and in your country. This section will focus on refining these problems into clear attainable goals and objectives for a successful advocacy campaign.

2.1 Goals and Objectives of the Campaign

The success of an advocacy campaign is measured by the extent to which the objectives are achieved. For this reason, take time to ensure the objectives of your campaign are developed to capture the spirit on which the campaign was founded.

Your campaign should set a broad goal from which more specific objectives can be developed. Your campaign goal is like your vision; it describes what you hope to accomplish in the long-term. It is vital that your goal bears a clear vision of exactly what you want to achieve. Campaigns can have different goals for different timelines. When developing your campaign strategy, it is important to consider different goals that you hope to win over a period of time. You may want to develop some short term goals that are steps toward your long-term goals. Short term goals are not always necessary but may prove to be useful in big issue campaigns - since it helps sustain organizations when people see small victories along the way.

Once this is done, break down the goal into your campaign objectives - the smaller, more specific policy changes that you want to accomplish - which can be tackled individually.

<table>
<thead>
<tr>
<th>Goal: To secure incentives for health workers at Furaha Health Centre.</th>
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<tbody>
<tr>
<td><strong>Objectives:</strong></td>
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<tr>
<td>• To initiate a worker-of-the-month award program for health workers at the health centre by April 2008.</td>
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<tr>
<td>• To acquire subsidized accommodation for health workers at the health centre by February 2009.</td>
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It is important to develop “SMART” objectives for your campaign.

- **Specific i.e. addressing a real need**
- **Measurable, i.e. can be subjected to monitoring and evaluation**
- **Appropriate, i.e. related to your needs**
- **Realistic i.e. can be achieved within your means**
- **Time-bound i.e. clearly stating when the objectives will be met**
In other words, your objectives should clearly state what it is you want to change, who will make that change, by how much and by when. Since you are trying to influence policy in this campaign, make sure your objectives are clearly linked to existing policies or new policies that need to be developed, or to existing investments or new investments that are needed.

Usually each goal should have no more than five objectives. Fewer objectives are generally more practical to achieve.

While developing your goals and objectives, remember that an advocacy campaign comprises eight steps, each one building from a foundation of the previous ones. Your objectives should therefore relate to the problems emerging from Section One. At this stage, you should postpone defining the details of the activities or tactics you will use to realize the objectives; these tactics will be developed after you have collected more data and decided who has the power to create the necessary changes in policy.

2.2 Tips for Developing Goals and Objectives

1. A series of smaller initial objectives with easy wins can provide the enthusiasm necessary to conquer larger, more involved campaigns.

2. Make sure your objectives include clear demands or policy asks. Don’t leave it up to the people you are trying to influence to decide what the solution should be, but instead make sure that your objective is built around the solution you want to see in place.

3. Your advocacy concerns may be too broad to be contained in one single venture. Do not hesitate to consider splitting your broader campaign into smaller stand-alone yet connected mini-campaigns. This may require you to rearrange and prioritize your advocacy issues to ensure cohesiveness and continuity.

Once you have developed your goal and objectives, you will need to identify the key partners who will help you push for the necessary changes in policies. The following section outlines the key steps necessary to build strong, effective and sustainable alliances that will help to improve the health workforce in your country.
Bungoma District Hospital Resource Centre

The lack of current information required to provide quality care to patients is a common cause of demotivation among health workers based at peripheral health facilities. The availability of resource materials like medical journals and facilities to connect to the internet not only serves to retain health workers in these rural facilities but also helps to bridge the rift between the quality of care provided to patients in rural and urban areas.

In January 2007 The Medical Officer interns at the Bungoma District Hospital teamed together in an effort to address this problem and developed the following goal and objectives:

GOAL: To develop a sustainable resource centre at the Bungoma District Hospital where health workers can readily access and share current and archived medical literature.

Objectives:
1. To obtain an accessible, secure room suitable to serve as a resource centre within 200 metres of the Bungoma District Hospital by March 2007.
2. To secure monthly subscription to two leading journals in the disciplines of internal medicine, surgery, obstetrics and gynecology and pediatrics by June 2007.
3. To acquire three desktop computers, one printer and one LCD projector for use at the resource centre by June 2007.
4. To secure a reliable broadband internet connection for use at the resource centre by June 2007.

The targets for their advocacy campaign were the hospital administration to allocate a convenient location for the resource centre and a leading pharmaceutical company to meet the costs for the resource materials for the centre including the internet connection. The team of interns scheduled meetings with the hospital Medical Superintendent and the regional manager of the target pharmaceutical company to present their case. In addition to this they collectively drafted a proposal, which they submitted with accompanying letters officially outlining their requests.

The requests were both supported almost immediately. A former store at the hospital was cleared out and within one month of sending out the letters and proposals work on the resource centre commenced.

The project has been a great success and at least three other health facilities so far around the country have undertaken a similar strategy.
Build Alliances and Coalitions

At some point early in your campaign, you will want to start thinking about who else you should bring to the table to be part of both the planning and the actions. Building alliances or coalitions may be an ongoing process throughout your campaign. You may invite some organizations and/or individuals to be part of the development of the goal and objectives for the campaign. Once the objectives are set, you may realize that there are additional allies that you would like to have as part of your coalition or alliance.

A coalition is a group of individuals and/or organizations with a common interest that agree to work together towards a common goal, often to execute a particular campaign.

There are both advantages and disadvantages to working in a coalition to achieve your advocacy objectives. A coalition may help you win what you would not be able to win alone by increasing the impact of an individual organization’s efforts, as well as increase resources. On the other hand, working in a coalition means that you may have to compromise on some of the issues that you take on, in order to build consensus. Keep the needs of your campaign paramount. If one key partnership will make all the difference, make it happen. If uniting more groups would create the momentum you need, build a larger coalition.

3.1 Levels of Participation

Collaboration is necessary to address nearly every health workforce challenge. However, there are many different levels of partnership and connection to choose from:

- **Get to know/consult other stakeholders**: Set up networking meetings with a variety of groups working on your issue or similar issues to see what they do, what has been successful for them and how you might work together. This can result in information sharing, invitations to events, brainstorm, etc that can help your campaign.

- **Establish a presence in existing networks**: Join existing networks and be part of their work and their collaboration. Many countries have AIDS coordinating bodies, NGO councils, human rights networks, etc. Join them, be a part, network, bring their actions to your members, and start to build your reputation as a good partner while bringing your campaign to a wider audience.

- **Build partnerships/coalitions with likeminded stakeholders**: This in itself has many levels—you can partner with one group for an entire campaign, or twenty groups for one event. For example, medical students wishing to engage in advocacy can look within the faculty, and get together with other student...
organizations to start a campaign to improve medical education. Or, medical students could start coalitions with the nursing and paramedical students to address shared needs in health education.

- **Build new policy networks:** If groups coming together believe they have long term interest in working together, you may want to formalize your coalition and actually create a new organization or formal network. For instance, AIDS and health rights groups in Kenya have come together to form the United Civil Society Coalition on AIDS, TB and Malaria—which itself is made up of a variety of coalitions of PLWA groups, health workers, NGOs and activists. This network creates an opportunity for all civil society to come together on issues around the Global Fund in Kenya, among others. This is a major step, and not one to be entered into immediately. Consult other groups, join networks and build small or large alliances, whatever suits your campaign—before moving to this option.

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**HWAF-U: Developing an HRH Advocacy Coalition in Uganda**

Developing a campaign around the health workforce can be extremely challenging. Because successful HRH strategies are complex and multi-disciplinary, there are many stakeholders and differing perspectives on how to define the problem.

The Health Workforce Advocacy Forum Uganda (HWAF-U) is a coalition of health professional associations, trade unions, and health rights organizations committed to addressing the health workforce crisis in Uganda. The goal of HWAF-U is to advocate for functional health policies that will lead to enhanced training, recruitment, and retention of health workers in Uganda.

The strength of HWAF-U is their diverse membership. Made up of representatives from Makerere University Faculty of Medicine, the Uganda National Association of Nurses and Midwives, the Uganda Medical Association, the Uganda Allied Health Professionals Association, the Uganda Medical Workers Union, the Uganda National Health Consumers Organization, the Action Group for Health, Human Rights and HIV/AIDS (AGHA), The AIDS Support Organization (TASO), the Voice for Health Rights Coalition and others, HWAF-U represents many of the stakeholders directly affected by the health workforce crisis in Uganda.

The challenge was to come up with a few relatively short-term, winnable, advocacy objectives that resonated with the diverse group while still charting a path towards addressing the larger, more complex issues that were extremely important to the HWAF-U members. After spending a few months doing research on the scope of the problem in Uganda and coming up with an overall goal for the campaign and three areas of focus, HWAF-U held a two-day advocacy workshop where they explored advocacy definitions, reviewed upcoming opportunities to influence policy, engaged with advocacy experts from Uganda and the US, and worked in small groups to develop concrete advocacy objectives and action plans. In the end, HWAF-U chose three areas of focus – or mini-campaigns – that all feed into the overall goal. By developing subcommittees to work on these issues while also meeting as a large group to strategize and review progress, HWAF-U will be able to use the strengths and interests of its members while still maintaining a clear and cohesive strategy that the full coalition can support.

Involving others is crucial to a successful campaign, but working with coalitions or alliances can make managing your campaign more complex. It’s important to understand the common challenges that coalitions often face so that you can address them in your campaign. Some guidelines for successful coalition building are included in Appendix A.
Get the Facts

Once you have a clear goal, specific advocacy objectives, and a number of allies who have joined the campaign, it’s time to make sure you have your facts straight. Facts must be directly related to your identified goal and objectives.

- **Facts are powerful**: They can help you determine advocacy priorities. How do the realities compare to the needs and government’s commitments? Facts can help determine unexplored or under-used policy possibilities. Are incentives in place to try to overcome inequalities? Has the government sought support from available sources such as the Global Fund to Fight AIDS, Tuberculosis and Malaria to help meet health workforce needs?

- **Facts are important for convincing policymakers of your positions**: Why should they listen to you? Because you know what you are talking about – you have the facts. It is one thing to say that the distribution of health workers is a problem. It is far more powerful to say that this district has ten times fewer health workers per capita than another district. It is one thing to say that more health workers are needed. It is far more powerful to point out that your country has only one-third the number of health workers that the World Health Organization considers a minimum requirement.

4.1 Information Gathering

In order to gather the information you need to begin your advocacy program, you will want to consider what information you need, where you can find that information, and who will help you gather that information.

**What information do you need?**

It is useful to think of this in terms of what questions you need answering. Where are the gaps in your knowledge? What are all the policies relevant to your issue? What demographic statistics will help make your case? Breaking down the required information into parts will help you plan to research it, particularly helping you to distinguish between information that will be easy to obtain, and that which requires more effort.

**Where can you find the information?**

The Ministry of Health might have much of the information you need, which you may be able to gather through meetings or gathering documents from ministry of health officials. Other ministries might also have some of this information, including the ministries of finance and education. Many answers might be contained in official policies, strategies, and reviews. The availability of these documents will vary by country. Coalition partners might already have some of this information. For example, an NGO that works on budgets might have information on health spending, and an NGO that works on HIV/AIDS might know whether money from the US global HIV/AIDS program, PEPFAR, is being used to support human resources, or who you can meet with in order to learn about PEPFAR policies. Your strategy for gathering information will therefore depend on the composition of your coalition, and whom you and different coalition partners know. A growing amount of this information may also be publicly available through the Internet.
Who will contribute to your information gathering?

Your efforts to find useful information can be a great way to reach out and network with other organizations and policymakers. You can call on other organizations to see what data they may have; can link with members of your own organization to share their stories; can interview key policy makers, patients and health workers to share info and views—indeed, the opportunities are endless to gather quality data while expanding your contacts and networking to meet your goal.

<table>
<thead>
<tr>
<th>Problem: Stigma against PLWHAs in Gombahari rural area in Murambinda</th>
<th>Advocacy solution: Encourage the community leaders to support people with HIV/AIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information/Evidence Needed</td>
<td>Source For Information</td>
</tr>
<tr>
<td>List of community leaders</td>
<td>District Administrator’s office; local churches (church register); public meetings</td>
</tr>
<tr>
<td>Map of catchment area</td>
<td>District Administrator’s office; draw our own map</td>
</tr>
<tr>
<td>Case studies of stigmatized people</td>
<td>PWHAs’ testimonials; NGOs; one-to-one interviews; meetings; records; publications</td>
</tr>
<tr>
<td>Numbers of people who are HIV+</td>
<td>Hospitals; Ministry of Health; National AIDS Control Program; NGOs</td>
</tr>
<tr>
<td>Information around stigma/policy, law, etc.</td>
<td>Zimbabwe National Network of People Living with HIV/AIDS; one-to-one interviews; analyzing and influencing legislation</td>
</tr>
</tbody>
</table>


4.2 Key Questions to Ask

Gathering facts is a process. You do not have to get all of this information at once. Don’t be surprised if some facts, and especially the most up-to-date information, are hard to find. Your advocacy goals will determine the types of information that you need. You will not necessarily need all of the pieces of information illustrated below. And you may require some information that goes beyond the scope of the questions below. These questions should, though, get you started in gathering the facts.

Health workforce numbers

- What is the estimate of the total number of health workers in your country (physicians/nurses/other categories)? How many workers of each category are there per thousand persons in the population, and how does that compare to WHO recommendations?

Health financing

- What is your country’s current health budget?
- Has your country estimated the total funding needed to provide everyone with essential health services, including AIDS treatment? How does the current health budget compare to that estimate? How does the budget compare to the commitment of governments to spend at least 15% of their budgets on the health sector, as African governments have committed to doing?
What percentage of the national health budget comes from international aid? Is this aid providing support for HRH?

How much of the health budget goes to human resources?

Are there wage ceilings or health sector budget ceilings? How does the government justify these ceilings?

What are international donors (e.g., PEPFAR, USAID, US Millennium Challenge Corporation, DFID, European Commission) doing to support HRH? Could donors do more to support HRH? Are any donors having an indirect impact (positive or negative) on HRH through their work?

Has the country applied for HRH support from the Global Fund to Fight AIDS, Tuberculosis, and Malaria or other sources?

Plans and policies

What policies currently govern the health workforce in your country? Does the country have a HRH strategic plan? How does it compare to the components included in the “Guiding Principles for National Health Workforce Strategies” (see Appendix B).

Has the country made projections on how many health workers are needed to meet the country’s health goals, including Millennium Development Goals and universal access to HIV services, and to provide other essential health services? What skills are most needed to address current gaps, and how can different cadres of health workers contribute? How do current policies and plans propose to fill those gaps?

Rural and other hard-to-reach areas

How does the availability of health workers in rural and other hard-to-reach areas compare with urban areas?

What current efforts are underway to increase the number of health workers in rural and other underserved areas? Are other efforts planned in the future, including addressing health infrastructure and the supply of medicines and equipment, incentives, the education system, and skills mix?

What protections are provided for health workers?

Has the government demonstrated a commitment to addressing the HRH shortage?

Education and retention

What are the current efforts to retain health workers?

Does the government have a strategy to more effectively retain health workers? What does this strategy entail? Is it comprehensive, addressing areas including salaries and benefits, working conditions, professional development, and supportive supervision? Are there causes of migration that the government is not addressing?

Is the country increasing the number of health workers educated in pre-service (do you want to be more specific here and say medical or nursing) training? Is the quality of training being maintained?

Are health workers paid a living wage?

Are all health workers able to follow universal precautions?

Are HIV services readily accessible by health workers? If not, what are the obstacles? What is being done to address this?

Are there unemployed or retired health workers who could be quickly recruited back into the health services?

Collaboration:

Are there groups or individuals working on HRH issues in your country? What solutions are they recommending?

Does the government have structures in place to enable health workers and NGOs contribute to health workforce planning and monitoring & evaluation?

What efforts are in place or planned to engage the private sector?
Choose your Targets

Once you have established your specific advocacy objectives and gotten the facts on both the issue itself and the power structures and decision-making processes behind it, it is critical to understand the WHO and the HOW:

- **Who** has the power to make the change you want, and is most vulnerable to the kinds of pressure you can mount?
- **Who** are your allies? Who could be your active supporters?
- **Who** will actively oppose you?
- **How** can we reach the people in power?

One process tool for this is called **power mapping**. Power mapping allows advocacy groups to systematically lay out power dynamics across your campaign so you can focus in on your main target—the one who can **make the change** you want to see—while also illuminating other potential connections and recognizing opposition so you can minimize it.

Power mapping is used to:

- Forge alliances
- Build support
- Do the most targeted actions
- Be politically relevant and strategic
- Build awareness and legitimacy of your group

5.1 Setting the Stage

You now have your goals and objectives and have done research on your issue—now it is time to examine the political landscape to see who can help you realize your goals—and who will try to block them. To begin the process of power mapping, identify all of the stakeholders and actors involved in your particular issue.

One helpful matrix to do this mapping is the power mapping tables included in Appendix D—it helps you map out your campaign allies, **beneficiaries, opponents, decision makers, and those who influence the decision makers**—all key power relationships to win a campaign.

- **Allies**: People who are “on your side” either because they will benefit directly or because they share the same objectives and want to help bring about change as part of a broader movement. These are the people and groups who are already active on your issue or those you want to enlist and you think you can get on board. 
  Ask yourself: who can you bring into this campaign as stakeholders and supporters?

- **Beneficiaries**: People whose lives will be improved by the successful achievement of your advocacy goals. They can also be called “allies” but without additional organizing, a beneficiary is often a more passive stakeholder than an ally.
Opponents: People who are opposed to what you’re trying to do and are likely to actively oppose you. Some of these people could become allies in time, with greater understanding of the issues, or could be standing in the way of what you’re trying to do. Adversaries can become targets of your advocacy project if you are planning a series of activities to “win them around.” Also, it is useful to not allow your campaign to get distracted by passive opponents – opponents who will not actively oppose you, or opponents who do not have the ear of your targets. Ask yourself: how can you ensure the opposition stays at least neutral—and that your actions do not necessarily inflame them to put opposing pressure on policy makers? Can you make any opponents into allies with specific outreach strategies?

Decision Makers: Those with the authority or power to make the desired change. Look at your list of decision makers and compare it to your objective and the policy/budget you are trying to change, and find the targets you have the greatest number of routes to reach. Ask yourself: are they vulnerable? Accessible? Accountable to your constituency or allies?

Influencers: Those who through their position, relationship, knowledge or status are able to influence those with the power of decision making, or the direction of policy changes. Ask yourself: who do you know who has the ear of your target? How can you influence them to move the target towards your position?

5.2 Identifying Targets

Now that you have mapped out the overall power dynamics in your campaign, it is time to focus on mapping out your targets. A “target” is the person who has the power to give you what your group wants in your campaign. A target is a person, not a faceless institution. Your constituency can easily imagine and express power over a person – but how can anyone have power over “the government” or “the International Monetary Fund”?

There are two kinds of targets: primary targets and secondary targets. The primary target is the person or institution with the ultimate power. See the box below for a list of potential targets for a health workforce campaign—this is just an initial list, and your targets should be based on the specific objectives, but this list may help guide you as you examine power structures in the health workforce policy and funding world. Your primary target should be someone who is vulnerable, accessible and hopefully accountable to your constituency and has the power to meet the demands of your group

Secondary targets are people who can influence your primary target. The opinions and actions of these “influencers” are important in achieving the advocacy objective in so far as they affect the opinions and actions of the decision makers. Some members of a primary audience can also be a secondary audience if they can influence other decision makers. For example, the Prime Minister and the Minister of Education might influence one another’s opinions. Therefore, they are both a primary audience (“targets”) and a secondary audience (“influencers”). In addition, your secondary audience may contain oppositional forces to your objective. If so, it is extremely important to include these groups on your list, learn about them, and address them as part of your strategy.

Some secondary targets may include:
- Leaders of target’s party
- Business associates of the target
- Personal Assistants or staff (to ministers, politicians etc)
• Formal or informal advisors to the target
• Relatives (spouses, children, uncles)
• Career middle management officers (Technocrats)
• National opinion leaders
• MoH, MoF, MPs: non-targeted Ministers may often be influential with your primary target. For instance, if the
  target is the MoF, and there is a Ministry of Health Official who is also an economist, he/she may be able to
  influence. Or if there is a member of Parliament who used to work at the Ministry of Finance, they may have
  influence there and can be a secondary target for this work.

A special note on targets
What does it mean to say target? The term “target” does NOT always imply that we are attacking them—but that they
are the decision makers who are key and around whom you should focus your efforts. Advocacy can often be most
effective when you approach your targets as colleagues versus adversaries: you are still targeting them and their
power, but in a collaborative light. Or, to make change, you may have to use more aggressive tactics towards your
target—either way, the target is the person who has the power to give you what you want, and it may or may not be
strategic to treat them as an adversary.

You can have more than one target for a campaign, although in general, fewer are better and allow you to be more
focused. There will often be a progression of targets on the way to victory in a complex campaign. If a “primary target”
is determined too hard to reach, but critical for your issue, you can make your secondary target your main target—so
if you can’t reach, say, the President, but you know he listens to a certain cabinet member, target them primarily to
reach the President.

<table>
<thead>
<tr>
<th>Some Potential Targets in Health Workforce Decision Making</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presidents or Prime Ministers</td>
</tr>
<tr>
<td>Questions to ask before you choose the President or Prime Minister as a target:</td>
</tr>
<tr>
<td>• Is there a more accessible target who can give us what we want without being overruled by someone higher up?</td>
</tr>
<tr>
<td>• If President/PM controls the budget, who does she or he get advice from?</td>
</tr>
<tr>
<td>• Is the spouse of the national leader a better potential target?</td>
</tr>
<tr>
<td>Ministry of Health Officials</td>
</tr>
<tr>
<td>• Planning Dept or the HRH department</td>
</tr>
<tr>
<td>• Commissioner or Director</td>
</tr>
<tr>
<td>• Minister of Health</td>
</tr>
<tr>
<td>Ministry of Finance Officials</td>
</tr>
<tr>
<td>• Minister of Finance</td>
</tr>
<tr>
<td>• Head of Macroeconomics</td>
</tr>
<tr>
<td>• Health Desk Officer at MoF</td>
</tr>
<tr>
<td>Members of Parliament</td>
</tr>
<tr>
<td>• Parliamentary Leaders</td>
</tr>
<tr>
<td>• Key Committee Chairs or members: Budget, Finance, Social Services</td>
</tr>
<tr>
<td>• MPs who are health workers themselves: doctors, nurses, etc.</td>
</tr>
<tr>
<td>Chairs/Members of National AIDS Planning Bodies</td>
</tr>
<tr>
<td>• National AIDS Councils</td>
</tr>
<tr>
<td>Representatives of Donors and Development Partners</td>
</tr>
<tr>
<td>• County Coordinating Mechanism (CCM) members or chairs who submit Global Fund applications</td>
</tr>
<tr>
<td>• PEPFAR Representatives</td>
</tr>
</tbody>
</table>
Power mapping is an art, not a science. And things change. So think about the criteria, but know they can be flexible. Targets depend on your objective, so targets in one campaign might be allies in another. Be flexible and ready to shift your targets and allies as the situation changes.

5.3 Framing the Message for Different Targets and Audiences

Once you have chosen your targets, your key messages will need to be “framed” or tailored according to the audiences you want to reach. While your overall position on the advocacy issue does not change, you should seek to adapt the way you present your message to achieve the greatest impact on a particular audience.

- **Whom to frame your message towards**: Your analysis of the issue and the people you chose as your targets will determine how you present your core message to that particular audience.

- **Tailor the message**: What is the most persuasive way to present your core message to the target audience? What information do they need, and what don’t they need? What key action do you wish them, in particular, to take?

- **Effective framing**: Which practical frame will make your message more effective? What should it contain? In what format should it be delivered? Length, images and even messenger are important.

**Crafting the message**

Policymakers are very busy and always have many advocacy groups vying for their attention. As a general rule, policymakers are most likely to listen and respond to you if your issue is:

- **Supported by their constituents**: When possible, use statistics or stories that relate specifically to their constituency or their main areas of interest. Find health workers in their region who can add testimonials or help collect data to make the presentation memorable and impactful.

- **Related to pending legislation, ordinances, and budgetary items**: Include details on the policy, on deadlines, on timelines, on international conferences (such as the Global Health Workforce Alliance Forum)—anything to give urgency to your demands and tie your demands to their responsibilities and public opinion around the issue.

- **Presented to them succinctly, using current data and simple language**: Policy makers are busy and will not read 100 page academic reports—but will read shorter fact sheets and policy briefs (see next section for tips on how to make these most effective).

- **Linked to them in a personal way**: If you can find a hook that gets policymakers to understand the issue in a personal way, they will be much more likely to take ownership of the issue and support your efforts. Policymakers in different arena often have widely divergent views and interests in the same subject. The Ministry of Health may respond to different messages than the Ministry of Finance, and Parliament may in turn be looking for a different set of information.
Consider a campaign on improving infection and prevention control in hospitals in order to protect providers and patients alike and improve working conditions to halt brain drain. Your message to various targets is likely to be different, depending on their interests and responsibilities:

1. **To MoH**: The Ministry of Health might be most interested in how low staffing levels may prevent them from meeting MDG goals—and how better infection prevention and control can boost health worker retention and productivity.

2. **To MoF**: The Ministry of Finance is focused on economic development and growth; pinpointing how brain drain hurts the economy, and how improving working conditions in health settings—starting with infection prevention and control—can help retain health workers and contribute to positive health outcomes. Remember—health IS a productive sector and Ministries of Finance must see the facts to prove this. Don’t be afraid to use statistics on how AIDS has slowed the economy, on how malaria decreases productivity, etc.

3. **To the President**: The President may be most interested in the region he/she is from, or in international perceptions, or in meeting the MDGs, or in economic development, or in an upcoming international forum—whatever he is most focused on is how you should tailor your message.

4. **To an MP**: An MP may want to hear specific statistics and stories about their home district. Depending on which committee they are on, they may also be interested in getting budget or health or labor information—again, an analysis of your target will help you figure out what themes and messages will move them.

5. **To the Media**: The media tends to gravitate towards sensational stories as opposed to dry statistics—giving them an example of poor infection control that resulted death or injury may get them interested, at which point you can emphasize your policy demands and get the coverage you need. For instance, in Uganda, the Ebola outbreak of 2007 focused the nation’s attention on the lack of safety in health centers.

As you can see from these different messages, audiences are motivated by different facts—so know your audience and know which facts will move them, and craft your messages to be most impactful.
Unfavorable working conditions of health workers in Kenya is a recognized cause of the health workforce crisis and a major challenge to the fight against HIV and AIDS in the country as well as the rest of the continent. In February 2007, students in the college of health sciences of the University of Nairobi as well as those of the Kenya Medical Training College Nairobi Campus partnered with Physicians for Human Rights (U.S.A) and the Kenya Health Rights Advocacy Forum (KHRAN) to organize a series of events set address the issues responsible for the health workforce crisis in their country. Among the problems identified by the students were:

- Poor remuneration of government-employed health professionals.
- Poorly maintained and inadequate health facilities and infrastructure.
- Inequitable distribution of health workers.

Goal: To secure favorable working conditions for health workers in Kenya

Objectives:

- To attain a government commitment to increase the budgetary allocation to health to at least 15% of the national budget by start of the next financial year (July 2008)
- To secure increased remuneration for health workers, particularly those working in remote health facilities, by the next financial year.
- To educate health workers in training on the issues relating to the health workforce crisis locally and globally and on their role in stemming the effects of the crisis.

The advocacy targets identified to achieve these objectives were health professional students at the University of Nairobi and the Kenya Medical Training College, specific officials from the Ministries of Health and Finance as well as those development partners from the USAID and WHO country offices.

Through a series of events dubbed the AIDS Week of Action, the students organized an advocacy training workshop for health students, and a public display of empty white coats to illustrate the shortage in the health workforce. The week of events culminated in an interactive meeting with key policy makers from the government and other relevant stakeholders. A petition highlighting the issues raised and signed by over 1000 members of the universities was displayed to those present and commitments were made by public officials towards addressing the students’ advocacy concerns.
Understand the Policy and Decision Making Process

In Section 5, we outlined how to choose a target. We selected the person who is the most open to influence, but who can still give us what we want, through “power mapping.” Now, we will “map” our way to get that person to give us what we want. We need to know how decisions are made, who has influence, and what structures exist for asserting your influence.

The policy-making process, in whatever governance context it takes place, is complex. There are a number of overlapping phases, and within them many sub levels. It is often subject to pressure, power and politics and often involves different groups with competing alternatives.

First, you need to learn and understand the public policy process in your country by determining where and how decisions are made. There is a tendency for NGOs to intervene in the later stages of the decision making process when the decisions have already been made. This limits the effectiveness of the intervention. This may be due to inadequate planning, not having timely access to policy decisions or documents, unrealistic policy response timeframes given by policymakers, or not being informed about the timeline for policy decisions. Understanding the policy context in your country can help your campaign get ahead of the decision-making process.

6.1 Understanding the Policy Context

When you analyze the way in which power is exercised, it is useful to be clear about the political environment in which you are working. The answers to these types of questions will help you effectively analyze the state of governance.

- What are the traditions and processes that influence how a decision is made?
- Is there a demand (or aversion) for research and new ideas among policymakers?
- What is the policy environment?
  - What are the policymaking structures?
  - What are the policymaking processes?
  - What is the relevant legal/policy framework?
  - What are the opportunities and timing for input into policymaking?
- What is the formal process for decision-making?
- How do global, national and community-level political and economic structures like PEPFAR or the IMF affect the decisions that policymakers make?
If you want to address health workforce issues, you will most likely want to influence the health budgeting process. Policy decisions such as budgets are often made on a set, annual timetable. If you are asking for money from the government to fund a policy, such as more healthcare workers, then you need to find out the government’s budget process. Typically, this process takes a good portion of the year, starting with the release of a proposed budget, followed by negotiations amongst the various policy-setting bodies, and concluding with a final published budget before the start of the new fiscal year. If the budget is formally released in late January, you can be sure that the decisions for how much money will go to specific line items in the health budget will happen well in advance. One rule of thumb is that conversations should begin three or four months before a decision is about to be released. However, it is never too late to get involved and to influence the decision.

Remember, important policymaking processes do not always reside entirely with national governments. Most Ministers of Health negotiate directly with foreign bureaucrats, or Mission or Embassy staffed offices that distribute funding from major unilateral programs such as the US Presidents Emergency Relief Plan for HIV/AIDS (PEPFAR). The planning bodies that create and submit country applications to the Global Fund to Fight AIDS, Tuberculosis and Malaria (CCMs) are supposed to be independent and include representation from civil society groups and people living with HIV, tuberculosis, and/or malaria. Beginning in 2008, they are also supposed to include people with expertise in health systems.

### The Role of Development Partners

In many countries there is no one single actor who develops and determines the human resources for health policies. While the Ministry of Health may be tasked with developing a comprehensive HRH plan, donors – also called development partners – and other major actors may be intricately involved in the process. The number of actors involved in the process will have a direct affect on your HRH advocacy campaign. For example, development partners may be implementing emergency hiring plans that create parallel human resource systems, or perhaps even draw health workers away from jobs in other private or faith-based facilities, contributing to what some call "internal brain drain."

It’s important to gather all the facts necessary to understand fully the impact of donor-driven HRH programs in your country, and to decide how best to incorporate development partners into your advocacy campaign. Every actor involved in the process and implementation of HRH strategies, policies and programs can be an effective part of the solution to the health workforce crisis in your country.

One campaign strategy is to insert your constituents – armed with a detailed agenda and set of demands – into these international bodies that develop or negotiate plans at the country level. You can also work with allied international groups to back up your demands and increase the pressure during these negotiations. This actually gives Ministers of Health more power over “development partners” and therefore more self-interest to find common cause with your group and agree to your campaign demands.

### 6.2 Creating a Campaign Calendar

Once you have your goals and objectives defined and your targets selected, the next step is to determine what opportunities you can leverage. Your campaign should develop and maintain a calendar of key dates where decisions will be made that are relevant to your campaign. Some questions to consider when choosing dates include:

- When are relevant policies being developed and when are the key decisions you need to influence being made?
- When are budget decisions made? When do the Ministries of Health and Education submit budgets to Parliament? When do Ministries submit budgets to the Minister of Finance?
What are the external events coming up that would help you raise awareness about human resources and the need for health care workers in the public, the media and among policy makers? What are the public events where your target will be present?

Campaigns should have a written calendar that includes dates of important events where your target will be present, and also regularly scheduled, ongoing activities such as outreach to your allies and partners. Below is an example of a campaign calendar. Events may not be scheduled quite this close together in your calendar, but it is important to have regular events and communications with allies in order to keep the momentum going in your campaign. Campaign calendars should typically include one month of activities, and be accompanied by a more general long term timeline.

**Sample Four-Week Campaign Calendar**

<table>
<thead>
<tr>
<th>1. Meeting with allies to choose goals &amp; target. Recruit 20 people to come</th>
<th>2. Create logo for campaign and write up campaign fact sheet</th>
<th>3.</th>
<th>4. Write letter to target asking for solution</th>
<th>5. Make follow up phone calls to people who came to meeting.</th>
<th>6.</th>
<th>7.</th>
</tr>
</thead>
</table>
AIDS Drugs for Africa: The Importance of Timing

U.S. Vice President Al Gore was the primary target of a campaign to win AIDS drugs for Africa in 1999, because he was running for higher office and needed to look good to his constituency of progressives and African American voters – exactly who the activists were able to mobilize to demand the new trade policy necessary to make AIDS drugs more accessible and affordable in developing countries. Candidate Gore was held accountable for demands that were also the responsibility of several U.S. Congress members, the U.S. Trade Representative or the President of the United States. But, the activists saw Gore as most vulnerable simply because he was running for office and therefore would be out in public where AIDS activists knew they could hold him accountable.

Vice President Gore chaired the U.S.-South Africa Bi-national Commission, and had used his power to punished early efforts by the South African Government to promote availability of affordable generic drugs. U.S. Aids activists checked in with South African civil society allies who were launching similar efforts. The groups decided to seize the opportunity to use Mr. Gore’s campaign announcement tour around the United States to publicize his harmful role and demand that he change U.S. trade policy to allow generic drugs in the Global South.

To start the campaign, a small group of activists drove to Gore’s hometown and held signs up that simply read “AIDS Drugs for Africa”. The next day, another small group of activists drove to another state where Gore would be campaigning. They got there early enough to get seats on stage and held up a banner behind Gore that read, “Gore’s Greed Kills, AIDS Drugs for Africa”. On the same day, a different set of activists joined a 3rd campaign stop and held up signs that read “AIDS Drugs for Africa”. Activists in South Africa had demonstrations with similar messages outside of U.S. embassies. These actions together led to an unprecedented wave of media coverage about the AIDS pandemic outside of the United States and the Vice President’s role in limiting affordable generic drugs in South Africa.

Activists usually have little access to senior U.S. officials like the Vice President— except for direct access afforded by campaign stops. By drawing media attention to the Vice President’s negative role at an extremely important moment for his campaign, the activists gained a great deal of power very quickly. They were quoted in news articles and quickly invited to high-level meetings to discuss the issue.

Within seven months from the start of the campaign, the very small group of activists had won a new Presidential Executive Order which lifted the central barrier to generic competition in developing countries. The cost of AIDS medicine quickly fell from $10,000 per patient per year to $350, and this price has continued to fall ever since.
The last thing to consider in strategizing a campaign is **tactics**, or **actions**. Actions are steps in carrying out an overall plan. In other words, actions are specific activities that you as advocates do to pressure targets. There are many different types of actions that can be used to achieve certain goals.

Below is a list of just some of the possibilities, but you should be creative and choose the actions that will help you meet your campaign objectives.

**Examples of Advocacy Actions**

- Conduct research
- Develop a policy proposal or policy brief
- Conduct meetings with elected officials or other policy makers to discuss the issue
- Hold a forum on a topic to educate the public or policy makers, or bring your group members to one of your target’s public meetings to raise questions
- Stage a protest, rally, march or vigil
- Conduct outreach or educational activities on the topic
- Write a press release and distribute it to media contacts
- Hold a press conference
- Create a scorecard which rates the performance of your target or of the government on the issue
- Write a shadow report which presents civil society’s evaluation of the issue
- Conduct monitoring by collecting information on your issue which can be written into a report or other publication
- Organize a debate on the issue to be held on the radio or TV
- Write a letter to the editor or an article for the newspaper or a journal
- Write a sign-on letter or petition to submit to public officials
- Hold a radio-talk show or some other media event to raise awareness about your position
- Participate in formal negotiations, such as collective bargaining for worker contracts
7.1 Criteria for a Good Action

When choosing actions for your campaign, you should evaluate each potential action using the following criteria:

- **It is focused on the primary or secondary target of the campaign**: Keep your focus on your key targets and name your targets publically when appropriate.
- **It puts power behind a specific demand**: The action must be aimed at someone and must make a specific demand.
- **It meets your organizational goals as well as your issue goals**: The action both builds the organization and helps you win the issue.
- **It is within the experience of your own members and they are comfortable with it**: Make sure your own members can be comfortable with the action, or else it will not be as successful. Often, however, a successful action will “go outside” the experience of your target.

7.2 Effective Presentation of Data

At least some of the actions you choose to carry out in your campaign will include some presentation of data and numbers. Data and numbers cannot speak for themselves—you must create engaging narratives which highlight your arguments and solutions and which are also concise enough to capture the attention of your audience. There are many options for how to present your data, depending on your target. Since fact sheets and policy briefs are often used in advocacy campaigns, we have also included some more in-depth tips on how to create these frequently used documents.

**Developing effective fact sheets**

Everyone is busy and policymakers are no exception. Oftentimes, they do not have time to read through lengthy reports, no matter how well written. A single sheet (can be double-sided) that highlights your position and top arguments is often more effective in getting your point across than longer documents. Commonly referred to as a “fact sheet”, this document is a summary of a specific problem presented in a clear format. Preparing accurate fact sheets to inform policymakers will establish your credibility and enhance your organization’s advocacy role.

A fact sheet should define the problem succinctly, indicate the breadth of support for your policy idea, highlight any successful models, and include suggestions for policy changes, as well as references. While you may be tempted to include every last bit of data you’ve collected on the topic, your main points might get lost. Rather, remember that clarity is critical. If your fact sheet is easy to read and understand, it helps make your case and reminds the recipient of your position after you have gone.

**Are our materials effective?**

An effective fact sheet:

- Summarizes the problem in one or two sentences
- Uses current data and supporting statistics
- Avoids “lying with statistics” or using misleading graphs
- Is written in simple language and is geared towards the audience it is meant to reach
- Includes the name, address, and telephone number of a contact person
- Uses headings to highlight the main messages you want to convey
- Is no more than one page in length (front and back)
- Might include a professional-looking chart or graph (e.g., bar chart, trend line graph, pie chart)
When you need to go into further depth than a fact sheet, a position paper or policy brief can be an effective tool. The following outline will help you to structure an effective brief to share with policy makers, the public and allies (and is only a guide—again, as with all presentations, be creative and tailor it to the needs of your target and your campaign):

1. **Statement of main recommendation:** One to two sentences to pull the reader in and state at the very start the main challenge and your recommendations.
2. **Background:** Explanation of why the position paper has been written. List of laws, international treaties, decrees, policies, etc. which support the recommendation.
3. **Evidence supporting the recommendation:**
   b. Qualitative evidence: Case studies, personal testimonies, anecdotes or examples supporting the recommendation (photos can also help stimulate interest).
4. **Analysis:** Logical explanation of how the evidence leads to the recommendations and answers to possible questions or objections.
5. **Recommendations:** Specific, realistic actions that the decision-maker can take.
6. **Organizations and individuals supporting this position paper.**
   a. The name of your organization or coalition, and logo if appropriate.
   b. The date.
   c. A contact name, address, telephone and fax number, and e-mail address, where available.
   d. The mission/goals of your organization or coalition.

Position papers can:
- Be left with an individual decision-maker at the end of a face-to-face meeting, to summarize the main points of your message;
- Be sent to local and national governments during consultation exercises;
- Be sent to people in influence, in response to a policy or action, to explain an alternative or supporting position;
- Summarize the resolutions of a conference or workshop
- Show that a coalition of many different allies supports your advocacy objective
- Be given to delegates or members of a committee at the beginning of a meeting or conference – whether or not you are allowed to speak at the meeting.

### 7.3 Launching Your Campaign

When choosing the actions that you want to use, you should also consider how you are going to “launch” your campaign. The campaign launch addresses the critical question of how to introduce your new campaign to your partners, the public and the decision makers you hope to target, and can be a very effective tactic that will help you achieve your objectives and goals.

You can choose a **formal launch**, during which you introduce your entire campaign in its final form with one large-scale event. A formal launch may take many forms, and often includes:
- A press release, and a press conference with members of the media;
- A march or other public demonstration of support for the campaign;
- Public speeches or testimonies highlighting the health workforce crisis in your country and supporting your proposed solutions.

It’s important to note that a formal launch should involve **as many partners, targets and stakeholders as possible**.
You can also choose an informal launch, which is a smaller event or activity that allows you to gauge people’s reaction to the campaign’s message and goal, and leaves room for you and your partners to make any necessary changes to the campaign that may enhance its effectiveness. A soft launch may take many forms, including:

- A breakfast forum where you invite key stakeholders to listen to campaign spokespeople and react to your message and goal;
- A meeting with a small group of members of the media, where you pitch your campaign and build interest in your issue and coalition;
- A small-scale launch of your campaign at the community level, where you can learn from community members’ reactions before launching your campaign on the national level.

**Good opportunities for a campaign launch**

A successful campaign launch must be well timed in order to draw attention and build momentum. Oftentimes, campaigns will begin on days of local, national or international importance, such as:

- World Health Day (April 7)
- Human Rights Day (December 10)
- World AIDS Day (December 1)
- International Workers Day (May 1)
- International Nurses Day (May 12)
- The launch of widespread national or regional policy initiative
- **Before** your government makes critical policy decisions affecting the health workforce

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**Professional Development through Continuous Medical Education at the Homa Bay District Hospital**

Health workers in remote facilities often lack professional development and as a result seek opportunities to work in urban centers where opportunities for career advancement through continuous medical education are available. This leads to a shortage of staff in the already strained rural health facilities through internal "brain drain."

In October 2006, the health workers in Homa Bay District Hospital felt the need to acquire a local solution to this challenge through partnering with relevant players in the district.

Their objective was to ensure a sustained series of regular, sponsored accredited seminars was available for interested health workers at the District Hospital.

The group chose a set of actions that were relatively simple for them to carry out themselves with limited resources, but that were also very effective. They first wrote a co-signed letter and a written proposal for the training program which they submitted to the Medical Superintendent (MS) and other senior officials at the hospital. As a result of this letter and proposal, the team gained audience with the MS and the senior officials. At this meeting, the team successfully gained support for their venture and apportioned funds to partially support their budget.

Despite this success, the group still suffered a short-fall of K.Sh. 120,000 per year. So, they needed to regroup and determine a new target and set of actions. The group approached the local Member of Parliament and requested a meeting, which was granted. After the meeting, the MP promised to present the proposal for the training program to the Constituency Development Fund Management Committee. The proposal was approved and the deficit was fully met. The seminar program has been successfully running for over one year.
Renew, Review, and Re-Energize

It can be quite challenging to sustain an advocacy campaign. It’s important to realize from the very beginning that it may take a very long time for your campaign to realize its goal, or for concrete, sustainable and effective change to take place. However, working with all the members of your coalition is critical to building momentum and realizing your goals. Continually work to expand and develop your network and partners, and push forward on an agreed path of escalation and negotiation.

It’s important to involve coalition members in reviewing and adjusting the advocacy campaign order to ensure that your coalition stays together, stays energized and stays focused. Keeping in frequent contact with your coalition, providing relevant updates and bringing the coalition members together from time to time to analyze the campaign strengths and weaknesses are all activities that help to build momentum and keep the energy level up.

8.1 Evaluating your Campaign

Every advocacy campaign will face numerous challenges—and numerous successes—along the way. Monitoring and evaluating your advocacy campaign allows your coalition to learn from both the gains and the losses and improve as you move forward to achieve your goals. An effective and honest evaluation will help your coalition grow stronger, and help your campaign achieve its goal. And, importantly, evaluating your campaign will allow you to demonstrate your campaign’s impact to funders and grant makers, as well as other potential supporters.

In general, there are two types of evaluations that you can use: “results evaluations” and “process evaluations.” A results evaluation focuses on whether you are getting where you want to go, while a process evaluation focuses on how efficiently you are getting there. The goals and objectives of your health workforce campaign will determine the best type of evaluation for you to use.

Process evaluation:

A process evaluation is the simplest type of evaluation to undertake. It evaluates the campaign process, and examines whether advocacy activities are reaching the intended audience, are occurring as planned, and are adequately funded. In sum, it evaluates whether or not the campaign activities are on track. It will answer questions such as:

- How many opinion leaders received information?
- How many pieces of educational material were distributed to the public?
- How many meetings were held with opinion leaders?
- How many members does the coalition have?
- How many articles covering the health workforce were placed in the media?

While a process evaluation is important for analyzing whether or not the campaign activities are on track, it does not evaluate whether or not your advocacy coalition has affected policy.

Results evaluation:

You can break down the field of “results evaluations” into two specific categories: evaluating the outcomes of your campaign, and evaluating the impact of your campaign.
**Outcome evaluation:**
An outcome evaluation measures the advocacy coalition’s intermediate impact. For example, if your goal is to improve the implementation of your country’s current HRH policy, then your objectives may be to raise the awareness of public administrators and elected officials of the current problems with the policy, among others. An outcome evaluation measures progress towards these outcomes, and answers questions such as:

- Has awareness of the problems with the current HRH increased among opinion leaders?
- How many more opinion leaders publicly support the campaign goal?
- Has the public’s support for your campaign increased measurably?

**Impact evaluation:**
An impact evaluation measures progress towards the long-range goals of the campaign. This is often the most expensive and time-consuming type of evaluation, so it is generally used to examine only the most ambitious advocacy efforts. An impact evaluation takes place some period of time after advocacy activities, and answers such questions as:

- Has the improved policy environment led to increased uptake of health services?
- Has the health worker shortage in your country, or inequitable distribution of health workers, changed measurably?
- Has access to health services changed measurably for groups such as women and rural populations?

### 8.2 Evaluation Tools
Below you’ll find a few online resources that may help you during your evaluation, as well as a sampling of tools, resources and guidelines to use at different stages of your campaign evaluation. Additional evaluation resources for advocacy campaigns are included in Appendix F.

**Continuous Progress: Advocacy Progress Planner**
http://www.planning.continuousprogress.org
This is a comprehensive online guide to planning, executing and evaluating your advocacy campaign. It provides a “logic model” for developing your campaign from start to finish, and each step of the program has an expansive glossary with tools and outlines available for download, as well as links to related resources.

**Continuous Progress: Skill Building for Evaluation**
http://fp.continuousprogress.org/node/93
This resource helps first-time evaluators build the necessary skills for an accurate and effective evaluation.

**British Overseas NGOs for Development (BOND): Monitoring and Evaluating Advocacy**
http://www.innonet.org/client_docs/File/advocacy/bond_monitoring.htm
This is an online guide outlining different strategies for monitoring and evaluating your advocacy work. It has a very thorough section guiding campaigners through the key indicators necessary to monitor your advocacy targets, your relationships, the media, your reputation and public opinion.

http://www.brunerfoundation.org/ei/docs/guide_for_nonprofits.pdf
This is a comprehensive guide, available online, to planning a participatory evaluation of a non-profit. It has several excellent tools for campaigners to use during their evaluations, including guides for focus-group facilitators, simple documents to help outline the evaluation plan, and participatory activities to incorporate into the evaluation process. However, the examples in this document are geared towards non-profit organizations that provide direct services; they will need to be adapted for your advocacy campaign.
Appendices

- A: Tips for Working with Coalitions
- B: Guiding Principles for National Health Workforce Strategies
- C: Good Practices in Health Workforce Retention
- D: Power Mapping Worksheet
- E: Conducting Advocacy-Focused Research
- F: Evaluation Resources
- G: Using Human Rights to Influence Policymakers
- H: HWAI References
Tips for Working with Coalitions

Guidelines for successful coalition building:

1. **Choose unifying issues.** The most effective coalitions come together around a common issue. Make sure the development of group goals is a joint process, rather than one or two group representatives deciding the goals and then inviting others to join.

2. **Understand and respect each group’s self interest.** There must be a balance between the goals and needs of the coalition and of the individual organizations.

3. **Respect each group’s internal process.** It is important to understand and respect the differences among groups. These differences are often apparent in processes or chains of command for decision-making. Make a commitment to learning about the unique values, history, interests, structure, and agenda of the other groups and organizations.

4. **Acknowledge and use the diversity of the group.** Every group has something similar AND different to offer, and every group’s ideas and influence can help the coalition succeed. Not everyone will always agree with everything the coalition does or wants to do, and sometimes the minority will be right. Make sure to take everyone’s opinion and restraints into account, and to use diversity as a spur to discussion, rather than a source of division.

5. **Communicate openly and freely with everyone.** Make sure that the lines of communication within the coalition and among the coalition, the media and the community are wide open. Open communication will ensure that no one feels left out, and that everyone has the information necessary to make coalition efforts successful.

6. **Structure decision-making carefully.** Finding consensus is very important when making decisions as a coalition. Every group must listen to each other, debate and discuss until they can find common ground.

7. **Distribute credit fairly.** Recognize that contributions vary. Appreciate different contributions. Each organization will have something different to offer. Each one is important, so be sure to acknowledge them all, whether they be volunteers, meeting space, funding, copying, publicity, leafleting, passing resolutions, or other resources.

8. **Be inclusive and participatory.** Work at making the coalition a group in which everyone in the community will feel welcome, and continue to invite people to join even after the first meetings. Try to involve everyone in the coalition in generating vision and mission statements, planning and major decisions. The more people feel ownership of the collation itself, the harder they will work to achieve its goals.

9. **Give and take.** It is important to build on existing relationships and connections with other organizations. Don’t just ask for or expect support; be prepared to give it.

10. **Develop a common strategy.** The strength of a coalition is in its unity. Work together with other organizations to develop a strategy that makes sense for everyone. The tactics you choose should be ones that all the organizations can endorse. If not, the tactics should be taken by individual organizations independent of the coalition.
11. **Be strategic.** Building coalitions in and of themselves requires a good strategy. Which organizations you ask, who asks them, and in which order are all questions to figure out. Are there organizations that have particular skills or perspectives that the coalition would benefit from? Or particular constituencies or relationships that would strengthen the coalition?

12. **Network at every opportunity.** Spread the word about your work and encourage other individuals or groups with similar goals to join. If groups in the community are informed of your work, they are more likely to be supportive, offer resources, and encourage others to join.

**Potential challenges:**

Bringing together diverse individuals and groups to reach common goals can be inspiring...and challenging. There are often barriers to starting a coalition, and it is important to be aware of them and to anticipate them. Among the most likely are:

- **Turf Issues:** Organizations and individuals may be sensitive about sharing their work. Part of the work of starting a coalition may be to convince a number of organizations that working together will in fact benefit them all and better address community issues.

- **Domination by one group or organization:** Coalitions are by definition diverse, and this diversity is part of what makes them strong. Make sure when starting a coalition that you create a participatory atmosphere and encourage everyone to give their ideas and time so no one group dominates.

- **Poor links to the community:** Coalitions must always keep in mind the community they are working to improve, and keep community concerns and needs at the forefront of their work.

- **Failure to provide and create leadership within the coalition:** Coalitions demand a very special kind of collaborative leadership, which can harness the strength of everyone involved. Cultivation of this leadership is important to coalition success.
Guiding Principles for National Health Workforce Strategies

Developed by the Health Workforce Advocacy Initiative
The Health Workforce Advocacy Initiative is the civil society-led network of the Global Health Workforce Alliance.

With global targets for major health improvements fast approaching, including universal access to HIV services by 2010 and achieving the health-related Millennium Development Goals by 2015, and the recognition that these goals cannot be achieved without building health workforce capacity, many countries are developing or re-assessing national health workforce plans. The development of health workforce plans, as well as broader health sector strategies, is receiving particular attention through such regional and global initiatives as the Africa Health Strategy 2007-2015 and the International Health Partnership, as well as the Global Action Plan on Human Resources for Health.

The following guidelines are intended primarily for the policymakers and other people involved in developing and evaluating these plans, including ministry of health officials, health workers, civil society advocates, development partners, and technical advisors. What should these plans – which should be country-developed and country-led – contain? How should they be developed, to give them the best chance of significantly improving health outcomes and moving countries as rapidly as possible towards universal access to essential health interventions? The guidelines should serve as overarching principles that will promote the success of health workforce plans, while ensuring that they are consistent with human rights. The right to the highest attainable standard of physical and mental health requires that these plans adhere to principles including equity, participation, and accountability, that they are based on major health needs of the population, that they make quality health care available, affordable, and accessible for everyone, that they represent continued progress towards filling this right, and that states spend the maximum of available resources towards meeting this and other human rights.

These principles begin with key considerations for the health workforce plan itself. The principles conclude with the context in which the plan should be developed and implemented, including financing and coordination with a broader health sector strategy. Many of the principles – such as those related to participation, monitoring and evaluation, and targets – also apply to that broader health strategy.

Targets

- **Aim for goals**: The health workforce plan should be targeted towards achieving health goals and commitments, including the health-related MDGs and universal access to HIV/AIDS treatment, care, prevention, and support by 2010.\(^1\) This entails calculating the levels of services required to achieve these goals, determining what cadres

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\(^1\) Health-related MDGs include reducing maternal mortality by three-quarters between 1990 and 2015, reducing child mortality by two-thirds between 1990 and 2015, and combating HIV/AIDS, malaria, and other major diseases. Other commitments include the African Union commitment to a package of essential health services for prevention, care, and treatment by 2015. The right to health has additional and complementary requirements, including creating the conditions to make medical services available to all, and focusing on certain health priorities such as maternal and child health.
(registered nurses, enrolled nurses, nurse practitioners, midwives, doctors, clinical officers, pharmacists, nutritionists, social workers, laboratory technicians, community health workers, etc.) of health workers will provide these services, the knowledge and skills these health workers will require, and how many of these workers will be needed, and then developing a plan that will develop, sustain, and equitably distribute these health workers. As a general rule, plans should both be ambitious – aiming to achieve these goals – and feasible, so with adequate support, they can in fact be implemented.

**Comprehensive approach**

- **Cover all aspects:** A comprehensive health workforce plan should address and, as appropriate to country circumstances, take measures to improve:
  1. Health workforce finance (such as salaries and incentives and the total budget for health workforce);
  2. Policy (such as the scope of practice for different types of health workers, guidelines on health workplace safety, and accountability of health workers, including management);
  3. Education (including pre-service and in-service health worker training);
  4. Partnership (including community mobilization and linkages between public and private sectors);
  5. Leadership (including leadership skills among HRH managers and leadership to ensure full implementation of the health workforce strategy), and;
  6. Human resource management systems (including systems for the collection and use of accurate information on the health workforce, supportive supervision, and improved productivity).

These are elements of the Global Health Workforce Alliance/World Health Organization HRH Action Framework.

- **Cover all cadres:** The health workforce plan should cover all cadres of health workers, both clinical staff, such as nurses, doctors, midwives, and pharmacists, and non-clinical staff, such as managers and support staff, and including all members of the care providing team, including nutritionists, social workers, and mental health professionals.

- **Cover all sectors:** The health workforce plan should cover all recognized health care providers, including public, NGO/faith-based, and private for-profit, and seek to utilize all providers in ways to achieve equitable, quality health services for all and that creates an integrated and coordinated health sector. It should also, as relevant, recognize the significant role that traditional healers play, and identify ways to effectively engage them, such as through counseling and referrals.

- **Link to broader development strategy:** The plan should incorporate ways that the health systems and health workers can contribute to broader development goals (such as through health workers educating communities on clean water, sanitation, and nutrition).

**Equality and non-discrimination**

- **Equitable distribution:** The health workforce plan should prioritize a more equitable distribution of health workers. The plans and planning process should assess the various aspects of the plan from perspective of equity and, wherever possible, incorporate measures to strengthen the health workforce in underserved areas, including through incentives; developing or expanding cadres of community-based health workers (including nurses and community health workers) and other cadres most likely to practice in rural areas (e.g., clinical officers/nurse practitioners); using the education system to enhance equity, such as through recruitment strategies, scholarships, and curricula, and; focusing resources on improving health infrastructure in rural areas.

Along with prioritizing equitable geographic distribution, the plan should promote a distribution of health workers among different levels of health facilities (health centers, district hospitals, referral hospitals, etc.) and professional practice areas (e.g., generalists, specialists) in ways that will enhance equity. Well-staffed primary
level health facilities and adequate numbers of generalists are particularly important for reaching underserved populations.

- **Marginalized populations**: The health workforce plan should be aimed at meeting the needs of often marginalized groups, including women, youth, elderly people, migrants, refugees and internally displaced people, gay, lesbian, and transgender people, people with physical and mental disabilities (including developing and retaining sufficient number of mental health workers, ensuring marginalized populations’ participation in developing the plan, and training health workers on the rights of people with disabilities, impoverished people, people living with HIV/AIDS, and rural dwellers).

- **Combating stigma and discrimination**: Programs should be developed and human resources assigned to address the stigma and discrimination within the health sector itself against marginalized populations, including people living with HIV/AIDS, injecting drug users, sex workers, and health workers providing care to stigmatized populations.

- **Gender**: The plan should address physical and sociocultural gender differences, including harms that may particularly affect women such as inequitable pay, unequal access to professional development opportunities, sexual harassment, and workplace violence.

**Workplace health, safety, supplies, and infrastructure**

- **Health worker health and safety**: The plan should secure health workers’ health and safety, including through measures to ensure consistent use of universal precautions as well as other forms of infection prevention and control, to provide health care to health workers including comprehensive HIV services, to provide for health workers’ physical safety, and to meet health workers’ psychosocial needs. Measures to identify and treat HIV-positive health workers should be taken in recognition of special confidentiality concerns that health workers face.

- **Adequate supplies and basic infrastructure**: The overall national health sector strategy in which the health workforce strategy is embedded should include measures to ensure that health workers have the medicines, supplies, and equipment they require to do their job, and that health facilities have meet basic infrastructure requirements, such as having electricity and clean water.

**Compensation and support, including for community health workers**

- **Living wages**: Health workers in all cadres should receive an adequate package of salary and benefits, including those at the community level such as community health workers. Different health worker cadres should be treated equitably.

- **Retention incentives**: Plans should include financial and/or non-financial incentives (such as housing allowances, lunch allowances, car loans, child care facilities, and increased recognition) and other strategies to improve retention (as addressed elsewhere), including attention to supportive supervision, good and safe working conditions, professional development, and respect of workers’ rights. Incentives should be designed to avoid intended distortions, which may happen when they cover a particular disease area or segment of the workforce.

- **Home-based and community health workers**: The plans should include measures to support home-based and other informal caregivers, as well as community health workers (e.g., HIV peer counselors, adherence support counselors). Community health workers should be compensated for their work, and should receive ongoing training, adequate supervision, supplies, and other support.
Education and training

- **Human rights and ethics education**: The health workforce plan should incorporate human rights education into pre-service training curricula for health workers. This education should include health workers' role in advancing these rights and should promote non-discrimination and respect for the rights of the diverse populations that health workers will serve. Health education should also address professional ethics including confidentiality, patients’ rights, and other such issues.

- **Task distribution**: The health workforce plan should address task-distribution and task-shifting in a manner that will ensure quality while increasing service delivery. Task-shifting may include creating or expanding new non-physician clinicians/clinical officers and community/lay health worker cadres, and, if so, it must strengthen related supervision and referral systems. Health-related education should address any resulting redistribution and mix of required skills and competencies. One consequence of task-shifting and the development of strong referral systems may be the need to expand the workforce to deal with newly identified patients with more complex needs. The plan should address recruitment, training, and retention of this additional workforce.

- **Pre-service education**: Pre-service education planning should be aimed at producing enough health workers, in conjunction with other measures, to achieve MDGs, Universal Access, and other health goals and commitments. Training should be aimed at national health needs, including primary health needs, and countries should consider innovative methods that might be used to accelerate expansion of pre-service training, if needed.

- **In-service training**: The health workforce plan should strengthen in-service training mechanisms so that health workers can be adequately informed and skilled to provide high quality care, including mechanisms to ensure training, especially on-site training, for health workers in rural areas (including possible use of information technology). The in-service training should contribute to continuing professional development.

Supervision and referral systems

- **Supportive supervision**: The plan should include measures to ensure that all health workers receive supportive supervision which in turn requires well-trained and well-prepared supervisors. The plan should address the resources required to provide regular supervision and to do so on site whenever possible. Supportive supervision is one way of providing quality assurance.

- **Connections to higher-level health services**: The plan should ensure that there is a highly functional, transparent, and dependable referral system that permits health workers to diagnose patients' health care needs, and then know how and to whom to refer patients promptly for more specialized or expert care when it is needed. This will be impacted by the skills mix and service delivery models, as well as factors like transportation and communications, which will likely be beyond the health workforce plan, and part of the broader health sector strategy.

Re-engaging health workers

- **Unemployed and retired health workers**: The plans should identify measures and policies that may be able to draw non-practicing health workers back into the workforce, including unemployed, underemployed, and retired health workers, and where appropriate to engage the country’s health professional diaspora.

Ensuring quality

- **Quality in education**: As health worker pre-service education is scaled up, as required in many countries, measures should be taken to ensure quality.
• **Regulating private sector:** Plans should include regulation of private health providers to ensure that they are delivering quality health services.

**Ready to implement**

• **Specific steps:** The health workforce plan should provide specific actions and timeframes for those actions that will be needed to implement the plan. If the health workforce plan does not have such specificity, a separate action plan should be developed.

• **Costing:** The health workforce plan should be costed. It may include several levels of costing, in the event that external resources that may be required are not forthcoming. If several costing scenarios are included, one should be the resources required to fully implement the plan and achieve health goals. All aspects of the plan should be costed, unless accompanied by a fully costed plan of action.

**Process of developing and implementing national health workforce plan**

• **Participation**
  
  ➢ **Broad participation:** The health workforce plan should be developed in a genuinely participatory and transparent manner, involving informed and wide participation of stakeholders that include NGOs, health workers, patient/health consumer groups, and representatives of often marginalized populations, such as women, youth, migrants, refugees and internally displaced people, people with physical and mental disabilities, people living with HIV/AIDS, impoverished people, sex worker and sexual minorities, and rural dwellers. This participation should inform the development of the plan.

  ➢ **Multi-sector collaboration:** The plan should be developed through multi-sector collaboration, including ministries of health, education, finance, and public service.

  ➢ **Communication with health workers:** Along with their participation in developing the plan, health workers should be widely educated about the health workforce plan and how it will impact them and their work.

• **Evidence base and flexibility**
  
  ➢ **Best available evidence:** Planning should take into account the best available evidence, including on workloads and disease burdens, including expected trends and the impact of emerging health issues like climate change. The effect of HIV/AIDS, including on health workers themselves, on workloads, on the need for chronic care, and on health workers’ tasks, should be taken into account.

  ➢ **Gather evidence:** The planning process should include activities to gather more evidence where current evidence is inadequate.

  ➢ **Flexibility:** Mechanisms should exist to revise the plan as necessary. As new evidence is developed, the plans should be adjusted based on the best available evidence.

**Monitoring and evaluation**

• **Monitoring and evaluation:** The health workforce plan should incorporate a monitoring and evaluation (M&E) process to monitor the plan’s implementation, to determine obstacles to implementation, to determine the effectiveness of the plan and its various elements (e.g., is the retention strategy working?), and to determine how the plan may need to be revised to improve its effectiveness in achieving its goals and improving health outcomes.
• **Information systems:** The plan should strengthen health information systems if they are not presently adequate to allow for effective M&E (and are one of the building blocks of health systems in their own right), as well as to gather evidence that will inform the plans.

• **NGO and health worker involvement in M&E:** NGOs and health workers should be meaningfully involved in the monitoring and evaluation process. Funds should be provided to enable broad stakeholder participation in both the initial planning process and in the subsequent monitoring and evaluation of the plan. People involved in other sectors related to the health workforce, such as education and agriculture, should also participate in M&E.

• **Public availability and accessibility:** The health workforce plan should be made publicly available and accessible to all, including by communicating it through accessible media and translating it into minority languages.

• **Link to right to health indicators:** The plan should include right to health indicators and benchmarks that permit monitoring to ascertain whether it is promoting the achievement of the essential elements of the right to health, namely, availability, accessibility, acceptability, and quality, and addressing both preventative and curative health services.

**Connection to broader health strategy to meet population’s health needs**

• **Linkages between overall health sector plan and health workforce strategy:** The health workforce plan should be linked to and harmonized with a broader health sector strategy (e.g., national health sector strategic plans). The connection to other health sector improvements is needed to help ensure that health workers will have the training, supportive supervision, and referral systems, and the medicines, supplies, equipment, and other tools that they require to effectively perform their responsibilities. Changes in other areas of the health sector should be factored into the health workforce plan, such as the impact the abolition on user fees will have on increased utilization of the health services. The priorities, goals, and service delivery models in the health sector strategies will also impact the health workforce plan. For example, integration of health services will maximize the ability of health workers to contribute to comprehensively meet people’s health needs.

**Financing**

The health workforce plan and the broader health sector strategy will have to be fully funded. The following are benchmarks, strategies, and policies that should guide this financing.

• **Increased domestic financing:** The national health sector plan should receive the maximum available domestic financing, including at least 15% of the government budget, as African governments have committed themselves to spending on the health sector. In many cases international financing will be required to supplement domestic resources, but such increases in domestic financing are a necessary step towards achieving full financing for the health workforce plan and national health sector strategy. An increase in domestic financing should not come through inequitable strategies that impede access to health services, such as point-of-service payments (user fees) on basic health services. Sustainable financing schemes should be designed to enable all people, including the poor, access to quality health services.

• **International financing:** Countries should coordinate their health sector and health workforce strategies and domestic funding with funding from bilateral and multilateral development partners (e.g., the Global Fund, GAVI). Development partners should commit to sustained funding that is predictable, long-term, rooted in national health strategies, and in conjunction with domestic resources, sufficient for full implementation of the health sector and workforce strategies. Development partners should also commit to paying recurrent costs.

• **Reformed macroeconomic policies:** The national health sector plan should be developed in concert with an evaluation and revision of existing macroeconomic policies, such as wage ceilings, deficit targets, and inflation.
targets, which may unnecessarily restrict the government’s overall fiscal space, thus limiting necessary investments and spending of domestic and donor resources.

Growth evidence demonstrates that a wide range of policies are consistent with macroeconomic stability. Country reviews of macroeconomic policy should present the range of possible alternative policies, and include an honest assessment of the risks and benefits of each possibility. Countries should choose those policies that will enable them to maintain macroeconomic stability while making the investments in health, education, and other sectors as required to achieve the MDGs and fulfill governments’ human rights obligations. Civil society members should be actively involved in these discussions.
Good Practices in Health Workforce Retention

Introduction
Africa’s shortage of health workers derives, in part, from a mass exodus of physicians, nurses, and other health professionals from the health workforce. Many leave for wealthy nations like the United States and United Kingdom, while others move to the wealthier of African countries, including South Africa and Botswana. Some leave the public sector\(^2\) for a more remunerative for-profit private sector, whose services are often unaffordable for much of the population. Others leave the health sector altogether.

How can countries retain their health workers, keeping them in the country and in the public sector? Below are numerous good practices in health worker retention. These do not include the full scope of interventions needed to address the health worker shortage, including increased investments in pre-service training and increasing the roles and responsibilities of less intensively trained health workers, with commensurate increases in their training, compensation, supervision, and other support.

The practices delineated below are designed to motivate a bold, human rights-based, comprehensive response to health worker retention. They are policies and practices that respond to the needs of health workers, who now leave in large part because neither their needs nor those of their patients are being met.

Evidence of successful health worker retention policies, particularly in Africa, is minimal. In some cases, countries may be making some of these interventions, but data is unavailable because the interventions are very recent or because monitoring and evaluation mechanisms were not incorporated into the interventions. Weak human resource information systems may also limit the ability to capture the results of interventions. Some of these interventions might not have been implemented, or have been implemented but only a small scale, perhaps limited in reach (a small number of health facilities) or scope (only minor improvements in human resources management). To the best of our knowledge, the comprehensive package of interventions suggested below has not been implemented.

The following measures either have been shown to, or can be expected to, contribute to health worker retention. The topics this appendix will cover are:

- General Considerations
- Human Resource Management
- Managing Public and Private Resources
- Salaries
- Incentives
- Training for Retention
- On-Going Training and Career Advancement
- Ensuring Health Worker Safety
- Reducing the Impact of HIV/AIDS on Health Workforce
- Building a Quality Workplace Environment

\(^2\) In some sub-Saharan countries, such as Zambia, the large faith-based medical service providers are highly integrated into the public sector, and effectively part of it.
General Considerations
When implementing health worker retention measures it is crucial that efforts be coordinated and that stakeholders be consulted. This will maximize buy-in from important groups and individuals and minimize health sector distortions.

- Implement “bundles” of interventions. For instance, if a plan is to include post-exposure prophylaxis for health workers, it should also include funding for providing gloves and other tools for universal precautions.
- Establish partnership with a broad range of stakeholders (MOH, NGO, private sector, community, professional organizations, donor programs). The more stakeholders are involved, the more influential actors will support the proposed reforms.
- Reconsider standing policies that reduce the pool of available health workers. One example would be raising or eliminating a mandatory retirement age to re-capture or retain seasoned and experienced health workers.
- Reduce barriers to hiring including streamlining paperwork or systems that increase times to fill posts. Where appropriate, decentralizing management activities such as hiring and firing may aid in this process (see below for Human Resources Management section). Hiring processes must be fair and transparent.

Success Story: Haiti
In Haiti, Partners In Health has taken a comprehensive approach to retaining their health workers in rural areas, including: ensuring reliable access to medicines and supplies; increasing health worker compensation (more than public sector but less than for-profit private sector); reducing social and professional isolation by providing satellite-based Internet connections and paying for regular travel to the city; holding weekly meetings to discuss cases; and; connecting the health workers to the larger AIDS world through participation in international conferences and forums. This has combined to lead to near perfect retention in an area with very high levels of attrition.

Ensure good HRH management and planning
According to The Manager, human resource management is “the integrated use of systems, policies and management practices to recruit, maintain and develop employees in order for the organization to meet its desired goals.”

Improved human resource management and planning can ameliorate multiple problems that contribute to health professional out-migration. Focus group interviews of South African nurses have identified the lack of options for career development and high ratios of patients to nurses as reasons for emigrating. Similarly, in WHD/AFRO’s six country study, about 80% of Cameroon health professionals cited lack of promotion as a reason for leaving, and about 40% of South African and Zimbabwean health professionals cited a heavy workload. More generally, more than half of Cameroon health professionals and more than 30% of Zimbabwean health professionals in WHD/AFRO’s study cited poor management as contributing to out-migration.

Poor human resource management can contribute to low morale because of five key questions related to job satisfaction that, when human resource management is poor, will all have negative responses. These questions are: 1. Do I know what I’m supposed to do? (The answer will likely be no without a clear job description.) 2. Do I know how well I’m doing it? (The answer likely will be no without feedback, including from supervisors.) 3. Who cares? (The answer will likely be no without feedback.) 4. Do I have a future in this organization? (The answer will likely be no without a well-defined career path.) 5. Am I being treated fairly? (The answer will likely be no without fair compensation, respect, and possibly other measures, such as performance-based promotions.)

Appendix C: Good Practices in Health Workforce Retention

References:
6. This is based on a framework developed by Management for Health Sciences.
• Ensure adequate human resources management and planning capacity within the health ministry. Where that capacity does not exist, strengthen the human resources sector of ministries of health by providing in-service training and hiring new staff with relevant human resource management skills. One example of an assessment tool is provided by The Manager at http://erc.msh.org/TheManager/English/V8_N1_En_Issue.pdf.
• Train health facility managers in human resource management.
• Incorporate health human resource management into pre-service training.
• Create criteria for organizations and governments to assess whether they have sufficient HRH management capacity to support a given scale up program. Identify areas of weakness so that they may be addressed before the scale up program is started. Significant technical assistance private sector, NGO and donor agencies will likely be needed for these assessments.
• Develop computerized database of health workforce, including private sector, to ensure up-to-date information on the present health workforce, its skills, its distribution, and other attributes.9

Success Story: Kenya10

In 1999, a coalition in Kenya implemented a human resource management program, COPE (Client-Oriented, Provider-Efficient). The program was designed to help transfer decision-making capabilities to on-site staff by teaching pediatric health care workers to identify and address problem areas. Tools were provided to health workers so that they may measure parameters involved in client and health worker satisfaction. Fifteen months after COPE was implemented, staff at COPE sites were more aware of quality improvement issues as well as the rights and needs of their clients. COPE health workers also exhibited better interpersonal skills, more accurate diagnoses and better home care instructions.

• Important responsibilities of human resource management that will improve health workforce retention include:
  ➢ Develop clear career paths for all health workers, including for mid-level and community-level health workers.11
  ➢ Develop clear job descriptions for all health workers.12
  ➢ Provide health workers regular performance reviews.13
  ➢ Help resolve disputes between employees or employees and managers.
  ➢ Ensure that employee complaints or requests are heard by top management.
  ➢ Help to ensure the equitable distribution of health workforce across the country.14

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9 For example, the Kenya Nursing Council, in collaboration with the US Centers for Disease Control and Prevention and Emory University, developed a computerized database of all nurses who registered in Kenya, including information on their training, health sector employment history, birthplace, and age. The database is now to the Nursing Council and the office of the Chief Nursing Officer in the Ministry of Health, and is in the process of being connected to several provincial nursing offices and health facilities. The Ministers of Health of the East, Central and Southern African Health Community passed a resolution in November 2004 in which countries were “urged to adopt/adapt the Kenya workforce study/project currently being undertaken by the Kenya Nursing Council as an example of a good practice in HRH information and document.” More information on the database is available through the Emory University School of Nursing’s website on the Kenyan Nursing Workforce Data Analysis Project at http://www.nursing.emory.edu/ncin/workforce.shtml.10
13 In some government clinics in Zambia, a review process adopted in 2000 involves reviewers from the district health office, local health centers, and NGOs who interview health staff and clients and observe health workers. The reviewers share their findings with health staff, provide scores, and discuss corrective actions. This system has contributed to improved performance, and represents the first real feedback health staff have received. USAID, Bureau for Africa, The Health Sector Human Resource Crisis in Africa: An Issues Paper (Feb. 2003), at 33. Available at: http://www.aed.org/ToolsandPublications/upload/healthsector.pdf.
• Upgrade payment system to ensure on-time payment of salaries.
• Consider moving towards a results-oriented performance-based system, where health workers receive regular feedback on their performance, and are rewarded (such as with promotions) for good performance, and sanctioned for poor performance.6
• Regularly inform health workers of policy change.6
• Develop strategies to minimize the time health professionals spend on activities that do not require their expertise. For example, utilize (or hire) other health facility staff to get medicines from the dispensary for patients, rather than use nurses for this task.
• Incorporate individual health facility workloads into decisions that affect health worker distribution. Develop strategies, which may include incentives or simply making more slots available, to increase number of health workers at health facilities with extra high workloads.
• Allow for feedback from workers to help shape their job placement. In Uganda, TASO takes their field officers’ requests for geographic placement into account when assignments are made. This has led to a high degree of worker satisfaction (100% report being satisfied with their placement) and has reduced early attrition.7
• Incorporate formal evaluation mechanisms to ensure that current interventions are successful and to change strategies for interventions that are not successful. For example, TASO changed its recruitment strategies to focus on potential field officers without formal health training to reduce recruitment from other agencies.8
• Supervisors should make regular visits to the workplaces of those they supervise in cases where they do not work in the same location. This will increase the supervisor’s understanding of workplace conditions, barriers to success as well as opportunities for improvement. Supervisors will thus be better equipped to advise.
• Promote a respectful and safe workplace including prevention of sexual harassment and management of interpersonal conflict. “TASO’s human resources department reported that two field officers who had left the organization have re-applied for the position, noting that TASO’s working culture and environment were preferable to higher salaries.”9
• Contract to private sector human resources companies who can rapidly implement changes while government bodies get up to speed. For example, in order to rapidly hire and deploy health workers from a variety of cadres, Namibia contracted with a private human resources provider to help successfully and rapidly identify areas in need of development in their health workforce.10 Human resource managers may also be able to broker harmonizing of salaries between government and NGOs.

Manage resource sharing between the public and private sectors.

It is crucial to manage dual job holding in the public and private sector. In one survey, 87% of health professionals in developing countries reported holding dual positions in the private and public sectors.11 Health professionals engage in dual job holding not only to increase their salaries, but also to increase access to resources and technology, improve recognition and professional opportunities.22

6 How to retain health workers in rural and other underserved areas is itself a subject of immense importance. Some strategies on more equitably distributing the health workforce are described in a Physicians for Human Rights guide on ensuring that human rights informs the human resources for health planning process, available at: http://physiciansforhumanrights.org/library/report-2008-02-01.html.
8 In the mid-late 1990s, Zambia’s health ministry “published a quarterly newsletter about the reforms that was widely distributed among health staff and kept them informed of the changes that were going to occur, the reasons for these changes, and the anticipated benefits that would be derived.” This contributed to high staff morale, good staff performance, and relatively low attrition rates. USAID, Bureau for Africa, The Health Sector Human Resource Crisis in Africa: An Issues Paper (Feb. 2003), at 35. Available at: http://www.aed.org/ToolsandPublications/upload/healthsector.pdf.
10 Id.
11 Id. at 9.

Appendix C. Good Practices in Health Workforce Retention
There are both positive and negative aspects of dual job holding. Negative aspects include drawing of publicly funded resources and personnel time away from the public sector and into the private sector. However, there are also positive aspects, which include allowing the public sector to retain health professionals despite severe financial constraints. Proposed interventions to reduce harm and increase benefits of dual-job holding include:

- Bans on dual job holding have been proposed. However, often bans are difficult to enforce and may lead to increased out-migration.
- Official recognition of dual-job holding. By officially recognizing dual job holding, governments may be better able to legislate and regulate this activity. For example, South Africa officially recognizes dual job holding and is able to award part-time or temporary contracts to private practitioners, thus increasing their public health sector workforce.
- Change the remuneration scheme of the public sector. In many countries, the public employees have fixed salaries while the private sector is fee-for-service. This encourages dual job-holders to spend more time attending their private practices and leads to neglect of their public sector responsibilities. If the public sector pay scheme were changed to include a component that will increase reimbursement for increased number of patients served or improved quality of care, the public sector may be better able to compete with the private sector.
- Link accreditation to performance in the public sector. This intervention will link service in the public sector to professional advancement, and will encourage improving the quality of care in the public sector.

### Provide competitive salaries, living wages

Health professionals frequently report that low salaries are often a significant, and sometimes the most significant, factor in the decision of health professionals to migrate. For example, in a survey of health professionals in Senegal who intended to migrate, 89% stated that uncompetitive salaries in the public sector influenced their decision, while 72% of Ugandan health professionals who intended to migrate who influenced by the desire for better pay. Of Zimbabwean health professionals who intended to migrate, 55% were influenced by a desire for higher remuneration. Conversely, the same study found that 68% of Cameroonian health professionals, 84% of Ghanaian health professionals, 78% of South African health professionals, 84% of Ugandan health professionals, and 77% of Zimbabwean health professionals reported that better salaries would encourage them to stay in their home countries. In all of these countries, better salaries were the factor most often listed that would influence the health professionals to remain in their home countries.

Despite these findings, some researchers suggest that the wage differentials between African and high-income countries mean that increasing wages within realistic limits will have limited impact on migration, and that other interventions might be more useful. One study points to the significant wage differential between South Africa and Ghana, where salaries are about five to six times higher in South Africa than Ghana for doctors and nurses, yet similar proportions of health professionals intend to migrate. The researchers suggest that non-wage interventions might be more useful at slowing migration. Nonetheless, even if large wage differences between countries remain, increasing salaries so that they can meet health workers’ basic needs could be an effective policy option. For example, a salary increase of 50% could improve retention if this makes salaries domestically competitive and enable health workers to meet their primary needs, even if the salary remains low by international standards.

24 Id.
27 World Health Organization, Regional Office for Africa (Magda Awases et al.), Migration of Health Professionals in Six Countries: A Synthesis Report (2004), at 48-49. Available at: http://www.afro.who.int/dsd/migration6countriesfinal.pdf. The only factor for which the study provides a percentage with respect to which would encourage Senegalese health professionals to remain is better salaries, which 90% of respondents listed. Other factors were also stated, but no percentage is available. Id. at 49.
In several cases, increased salaries do appear to have improved retention. In Ghana, doctors received large increases in financial compensation through the Additional Duty Hours Allowance, slowing the emigration of physicians. For example, the medical director of a teaching hospital in Accra, Ghana, credited the ADHA with enabling his physician staff to increase from 380 to 430 over a four year period. Kenya doubled salaries for physicians in 2002. This appears to have contributed to a doubling of public sector physicians, though other factors, such as medical school’s having doubled their intake, also contributed to the increased number of public sector physicians. Similar results are found for nurses. Malawi faced a severe nursing shortage in the late 1990’s and introduced a number of interventions including a salary supplementation plan as well as improved benefits such as free staff housing. As a result the number of nurse tutors and instructors has increased and subsequently has remained relatively stable.

Success story: Zambia

In Zambia, with U.S. and Dutch support, at least 66 physicians are serving on a three-year contract in rural areas, receiving a hardship allowance, an accommodation allowance, an education allowance for the doctors’ children, eligibility and some funding for post-graduate training, and eligibility for a loan. PEPFAR, which is supporting about half of these physicians, reports that its support has enabled 5,000 people to receive ART who wouldn’t have had access to AIDS treatment otherwise.

Retention can also improve retention of less intensively skilled health workers who are not likely to emigrate, but might nonetheless leave their job. A study of community health workers in Gongola State, Nigeria, found that male community health workers with higher pay stayed an average of 3.25 years, compared to two years for their counterparts with lower pay.

Other countries have introduced salary increases for some or all health professionals. With assistance from the United Kingdom and other development partners, along with its own funds, Malawi increased pay for health workers by 52% in April 2005. South Africa implemented a scarce skills allowance in 2004, providing additional compensation to certain categories of health professionals, including physicians, pharmacists, and nurses with certain specialties. Nigeria created a Medical Special Scale to enable physicians to receive higher pay than other civil servants.

- Provide health workers internally competitive salaries for people of comparable skill levels. Ensure that health workers have living (non-poverty level) wages.
- Provide salary increases or top-offs for those health workers who are placed in more resource-poor or rural areas.

• When adjusting government health worker wage levels, coordinate with not-for-profit health providers to avoid inadvertently drawing health workers away from these services, which may reach people whom governments services do not reach.  

• When adjusting government health worker wage levels, ensure fairness among different health professions, including by avoiding too significant a wage differential between physicians and nurses. 

• Agreement with donors and NGOs that if they must hire a health worker from the public health sector, they will support a transition strategy that avoids disruption of the public sector health services, including if appropriate funding for training and/or salary support for a replacement. 

• Macroeconomic policy reform. IMF encouraged or inspired wage bill caps and overall strict budget restrictions stand to prevent governments from increasing wages and providing incentives that could mitigate health workforce brain drain. In some cases, caps on the wage bill may even lead to desperately needed health workers remaining unemployed. In order to improve retention of health workforce through increased remuneration, the IMF and finance ministries should:
  - Eliminate wage bill caps and allow the wage bill to be determined by staffing needs. 
  - Loosen overall budget restrictions and take into account social policy targets when creating macroeconomic targets. 
  - Welcome and support civil society participation in determining appropriate macroeconomic policies. 

Supplement salaries with additional material incentives

Along with salary increases, governments can increase the compensation of health workers through other benefits. These non-salary material benefits may be of particular value where civil service policies, macroeconomic constraints, or other factors prevent or restrict salary increases. The WHO/AFRO study speaks to the positive impact these could have on retention. When asked what would motivate them to remain in their home countries, attractive fringe benefits were the second most popular response from Ugandan and Zimbabwean health professionals, at 54% and 71% respondents, respectively, and the third most popular response by Ghanaian and South African health professionals, at 78% and 66% of respondents, respectively.

Success Story: Ethiopia and Ghana

Ethiopia offered a non-financial package of benefits to its physicians. The package included subsidized housing, continuing educational benefits, and a more defined career structure for each health professional. This package has been well received and has led to measurable improvements in morale, job satisfaction and health worker retention. In Ghana, an awards package combined with team building efforts and closer supervision contributed to higher coverage of immunizations and antenatal care in rural districts, and to fewer applications to transfer out of these districts.
Various countries have used non-salary financial and material incentives in an effort to improve health staff retention and motivation. These incentives include housing allowances and affordable housing in Zambia and Ghana, respectively, cars for some health professionals in Ghana, and a lunch allowance for Ugandan health workers.

Another particularly useful incentive could be providing health workers health insurance or an allowance to attend to their medical needs, as well as paid sick days. Along with the economic value of these benefits, they should contribute to improved health of the health staff, thus reducing frequently high rates of absenteeism among health workers, and even helping save their lives.

- Prior to implementing a non-financial incentive plan, countries should undertake a stakeholder consultation.
- Provide health workers good benefits, which may include health insurance or a medical allowance, school fees for children, paid sick days, a lunch allowance, a housing allowance, and a vehicle or transportation allowance. There are many examples of non-financial incentives having significant impact on employment and retention of health workforce. For example, Kenya, in 2002, introduced a package of benefits for physicians that included risk and extraneous allowances. This intervention attracted an additional 500 physicians to the public health sector.
- Reduce length of time before health workers are eligible for promotion.
- In order to address geographic imbalances, some countries have had success with limited-time bonding agreements in exchange for loan forgiveness. Malawi has employed this tool to increase nurse density in rural areas. In addition, Malawi also offers free post-basic or post-graduate training to public sector employees, which has helped to maintain workforce in the public sector.
- When providing benefits ensure fairness among different health professions, including by avoiding too significant a benefits differential between physicians and nurses.

Training for Retention

Focusing on training programs represents another avenue to address retention of health professionals. With two-thirds of sub-Saharan African countries only having one medical school and 11 having no medical school, there is a clear shortage of training programs. This shortage necessitates would-be health professionals to seek training abroad. All too often these health workers do not return to their countries of origin.

In addition, training programs that do exist may focus on tertiary care aspects or teach towards licensing exams such as the United States Medical Licensing Examination (USMLE). These training priorities do not address the most salient health problems of local populations nor

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43 Zambia provided a housing allowance to all civil servants, though this and other salary increases ran afield of wage bill limitations agreed to with the International Monetary Fund. This led to a freeze in civil servant salaries and a reduction of the housing allowance. Bretton Woods Project. Life under the IMF’s magnifying glass: A Zambian civil servant chafes at the collar (April 5, 2004). Available at: http://www.brettonwoodsproject.org/article.shtml?cmd=x-128-42221. As of October 2004, Ghana was in the process of securing a $10 million loan to build affordable housing for health staff. “Ghana: Special report on struggle to stop exodus of doctors and nurses.” U.N. Integrated Regional Information Networks (IRIN), Oct. 3, 2003. Available at: http://www.irinnews.org/S_report.asp?ReportID=36969&SelectRegion=West_Africa.


46 Zambia provided a housing allowance to all civil servants, though this and other salary increases ran afield of wage bill limitations agreed to with the International Monetary Fund. This led to a freeze in civil servant salaries and a reduction of the housing allowance. Bretton Woods Project. Life under the IMF’s magnifying glass: A Zambian civil servant chafes at the collar (April 5, 2004). Available at: http://www.brettonwoodsproject.org/article.shtml?cmd=x-128-42221. As of October 2004, Ghana was in the process of securing a $10 million loan to build affordable housing for health staff. “Ghana: Special report on struggle to stop exodus of doctors and nurses.” U.N. Integrated Regional Information Networks (IRIN), Oct. 3, 2003. Available at: http://www.irinnews.org/S_report.asp?ReportID=36969&SelectRegion=West_Africa.


51 Nurses were largely bypassed in the allocation of cars in Ghana, were under initial allocation of cars, nurses received only 5 of 200 cars. At least part of the reason is that the Ghana Medical Association was involved in allocating cars, whereas the Ghana Registered Nurses Association was not. Focus group discussions found that this contributed to nurses feeling undervalued and expendable. DFID Health Systems Resource Centre (James Buchanan & Delanya Davio), International Recruitment of Health Workers to the UK: A Report for DFID (Feb. 2004), at 21. Available at: http://www.dfidhealthrc.org/Shared/publications/reports/int_res/nt_res-main.pdf.

do they teach towards the available resources. Concentrations of health training programs in urban areas also help lead to the extreme geographic maldistribution of health workforce within countries.

- Training should be tailored to the needs of the local population and should reflect the resources available to the health professionals, including in primary health settings. In many cases, this will mean that public health should be stressed over technology-based techniques. Training that prepares students to pass a test used in wealthy countries such as the USMLE rather than to meet local needs ill prepares students for the on-the-ground realities of local health care, and may accelerate out-migration. The Joint Learning Initiative recommends that “in every unit of the educational programme the emphasis is on those topics objectively determined to have a large impact on the health status of the population – or subjectively experienced at the community level to have such impact.”

- Train health workers in geographic locations of need. This strategy aims to alleviate the geographic inequalities of health workforce within country.
  - Create new training centers in rural areas. For example, the Ghana ministry of health has created six additional community health nurse training programs in past 3 years, so that a program exists in each of the country’s regions, and can better local health workforce needs. These programs recruit from local populations who are more likely to remain local. Locating training programs in communities where nurses would work was also found to facilitate relevant field training and provide nurses with job satisfaction related to the fact that they were a vital part of the community.
  - Support contextual learning. Urban training programs may support rural experience and service through programs like the Community-Based Education and Service program at Moi University, Kenya, and at Makerere University in Uganda.
  - Utilization of distance learning. Similarly distance learning allows health workers to be trained in their regions of origin. Distance learning has been shown to be an accepted and cost-effective training mechanism.

**Success story: Ghana**

Ghana is training and deploying Community Health Officers, nurses with approximately two years’ training, to be based in the communities they serve, rather than in more distant health facilities. By the end of 2004, Ghana had trained 310 of these Community Health Officers, who were helping bring care to nearly 1 million people. One district saw its childhood immunization rate triple, maternal and child mortality fall significantly, and the rate of tuberculosis defaulters drop from 73% to 0%.

**Provide continuous learning opportunities and career advancement**

Too often, health professionals seeking to upgrade their skills and advance in their careers and abilities find that they cannot because the educational opportunities are unavailable. Multiple studies have demonstrated that lack of career advancement is among the top three “push” factors mediating health worker migration. Curriculum: Continuing professional development should be tied to relevant clinical, administrative, or leadership training needs.

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54. Id. at 12.
58. Id. at 8.
60. Id.
• Implementation: Continuing professional development should be regularized by creating laws obligating reasonable standards of continuing professional development for all cadres of practitioners and by creating legal frameworks and administrative bodies to support its implementation.  

• Provide funding to travel to conferences or present at conferences.

• Create learning opportunities that are accessible to health workers, including using distance-learning and internet modalities. Distance learning has several benefits. It enables students to learn at their own pace, and improves productivity by allowing health workers to remain in their place of work rather than spend time traveling to courses.

• Offer certificates of achievement for completion of courses or trainings.

• Make available continuing education opportunities that will contribute specifically to career advancement. Examples include offering or supporting participation in a course on basic clinical research methods.

• Reward health workers who are interested in and excel at instruction of aspiring health workers. Advanced titles or material incentives may be offered.

• Within institutions, create awards which recognize skilled instructors, excellent clinicians or promising researchers. These awards may be accompanied by a stipend to attend a conference or course.

• Encourage clinicians and student clinicians to submit case reports to relevant journals.

• Create and support gradations within health cadres. Promotion from one grade to another may be based on years of experience, clinical expertise or special abilities such as excellence in instruction. Advancement may come with special titles, increase in pay or other material benefits.

• Provide access to on-line resources and databases. This may be accomplished through partnering with sponsoring institutions or agreements with the on-line service providers. In a small survey of physicians-in-training in Botswana, improved library resources was cited as one reason why these physicians-to-be would stay in Botswana to practice.

Ensure health worker safety

Poor working conditions and fear of occupational infection are consistently cited as a major contributor to out-migration of health professionals. In WHO’s Regional Office for Africa’s six country study, a desire for a safer environment was the fourth most important reason to out-migration cited by Cameroon health professionals, and was also cited as a reason by more than 25% of South African and Zimbabwean health professionals. A study of Malawian nurses who had emigrated found that 25% cited lack of protective gear as a reason for leaving – the third most important reason -- and fear of contracting HIV/AIDS through work-related accidents has also been identified as a significant push factor in Zambia.

• Enable all health workers to practice universal precautions, simple infection control measures that reduce risk for transmission of bloodborne pathogens, including HIV. This requires all health facilities to have consistent, adequate supplies of gloves and other protective gear, as well as to ensure that all health workers are trained and successfully applying in universal precautions.

• Ensure that post-exposure prophylaxis (PEP) is available to all health workers. Along with the availability of the drugs, health workers should be trained in PEP, and sensitized to the issue of needlestick injuries so as to eliminate the frequently held but false notion that a sharps injury implies poor performance.

• Implement additional infection prevention and control measures, including introducing syringes with safety features to minimize risk of needlestick injuries. Health worker should have the opportunity to participate in selecting the equipment that they feel is most appropriate to their circumstances. Along with increasing health

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63 Regional Network for Equity in Health in Southern Africa (EQUINET) and Dafam (Great Britain) (Jean-Marion Atkken & Julia Kemp), HIV/AIDS, Equity and Health Sector Personnel in Southern Africa (Sept. 2003), at II. 25. Available at: http://www.equinetafrica.org/bibl/docs/hivpersonnel.pdf.
65 Regional Network for Equity in Health in Southern Africa (EQUINET) and Dafam (Great Britain) (Jean-Marion Atkken & Julia Kemp), HIV/AIDS, Equity and Health Sector Personnel in Southern Africa (Sept. 2003), at 23. Available at: http://www.equinetafrica.org/bibl/docs/hivpersonnel.pdf.
workers’ sense of safety, the respect demonstrated by that providing these safer devices and should also contribute to health worker retention.

- Provide hepatitis B vaccinations to health staff, who are at risk of hepatitis B through exposure to contaminated blood.
- Ensure the safety and well-being of women in the health workforce by providing them with a work environment that is free of harassment and physical danger, including gender-based violence.

Success Story: Thailand

In 2000, as part of a WHO initiative, Thailand conducted a survey of its hospitals and clinics to assess the prevalence of workplace violence as well as interventions being taken to reduce the violence. The findings revealed that Thailand has taken the issue of workplace violence to heart. Thailand has instituted policy around reporting and reacting to workplace violence and has an array of interventions already underway ranging from restricting public access to areas of health centers to assessing patients for potentially aggressive behaviors to educating staff about protocols for dealing with potentially violent situations. The assessment also revealed that these measures in many cases made staff feel safer and more confident in their workplace.

Many of the above actions, such as improving health worker safety, will demonstrate respect for health workers. Other policies can also demonstrate national respect for health workers.

- Incorporate feedback into workplace policies. A study of nurse productivity in Botswana found that nurse participation in workplace policy-making significantly improve productivity. Regular queries of worker needs should be included.
- Incorporate stress management sessions and other psychological support to help workers feel heard and reduce burnout.

Reduce Impact of HIV on health workers

HIV epidemics in the developing world disproportionately affect health workers, leading to increased sick days and decreased productivity of health workforce. By improving the care of health workers living with HIV, one may improve their performance.

- Incorporate workplace policy explicitly protecting the rights of PLWHA.
- Provide HIV-positive health workers with INH prophylaxis and cotrimoxazole in order to protect against tuberculosis and other opportunistic infections.
- Provide ARVs to health workers who are at clinical need.
- Offer workplace education on HIV prevention and management to ensure that health workers remain healthy for as long as possible. Offer workplace confidential testing, linked to treatment, to encourage early diagnosis and treatment of HIV within the health sector.

Ensuring a Quality Workplace Environment

In addition to low pay, lack of resources leading to the inability to provide quality care has been cited in many surveys as a major factor leading to brain drain. In order to remedy this push factor, increased resources and improved supply chain management must be addressed. Although this is somewhat beyond the scope of this menu of interventions, it is important to cite as a key factor in workforce retention.

- Consider providing discretionary funds to health facilities that health staff control and use to meet their priorities.

Appendix C: Good Practices in Health Workforce Retention

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• Improved supply chain management and cold chains to ensure prompt, reliable delivery of basic medications and other supplies such as tape, gloves, syringes, and needles.

Success story: Swaziland

Health workers often have severe challenges accessing HIV services due to issues of stigma and confidentiality (being cared for by their co-workers, and fear that they will lose authority if their patients know they are HIV-positive). In response, in September 2006, Swaziland opened a Wellness Centre of Excellence for Health Care Workers, and Malawi, Zambia, and Lesotho are following suit. The Wellness Centre provides a range of services, including HIV counseling, testing and treatment, stress management and psychological support, pMTCT, treatment for TB and occupational injuries, and home-based care, for about 6,000 health workers and their immediate families. 1 Reportedly, in part due to this Centre and due to other factors as well, not a single nurse has emigrated from Swaziland since the Wellness Centre opened.

• Involve the community via consumer forums to provide feedback to providers and institutions. This will help to ensure that health care is meeting the public’s needs.

• Make promotions, bonuses, and raises contingent on quality of care provided. This intervention will require additional resources in order to measure quality. However, simple measures including surveying charts to see if patients are on appropriate medicines for given conditions may be employed. Other less-resource-intensive mechanisms such as measuring patient satisfaction may also be employed.

Success story: Nigeria

In Ondo State, Nigeria, a new state government in 2003 surveyed health workers as to their needs, and 62% said that their primary need was adequate levels of medicines, supplies, and equipment. The government prioritized this need, including in rural areas. Combined with other development measures (such as building roads to areas previously reachable only by boat), this contributed to a rapid increase in the proportion of nurses in the state serving in rural areas, from 28% to 66%, over a period of about 3 years.

Conclusion

While this appendix illustrates a large variety of interventions to improve health workforce retention, each country must assess its individual situation, resources and needs in order to implement a health workforce retention strategy. Health workers should be central to this decision-making process. This document is meant to provide examples and resources that may inform such a strategy.

69 In the mid-late 1990s, health staff in Zambia used a portion of fees from the country’s cost-sharing program to purchased needed supplies. This contributed to good staff morale. USAID, Bureau for Africa, The Health Sector Human Resource Crisis in Africa: An Issues Paper (Feb. 2003), at 35. Available at: http://www.aed.org/ToolsandPublications/upload/healthsector.pdf. Since user fees reduce access for poor people to health services, Physicians for Human Rights suggests that countries use other means of finding funds that health staff can control and use to meet their priorities.


Power Mapping Worksheet

When using this worksheet, remember that this matrix is not static, nor are the lines strictly drawn. Groups may move from being opponents to being allies (or vice versa) as your advocacy work progresses, so it is critical to analyze this power map and keep returning to it to see what roles may have changed.

### STEP ONE: SETTING THE STAGE

<table>
<thead>
<tr>
<th>ALLIES</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>BENEFICIARIES</td>
<td></td>
</tr>
<tr>
<td>OPPONENTS</td>
<td></td>
</tr>
<tr>
<td>DECISION MAKERS</td>
<td></td>
</tr>
<tr>
<td>INFLUENCERS</td>
<td></td>
</tr>
</tbody>
</table>

**Key Follow Up Questions:**

1. **Allies and Beneficiaries:** Who can you bring into this campaign as stakeholders and supports? How can you build a coalition that capitalized on the strength of these allies?

2. **Opposition:** How can you ensure the opposition stays at least neutral—and that your actions do not necessarily inflame them to put opposing pressure on policy makers?

3. **Decision Makers:** Look at your decision makers list and compare it to your objective and the policy/budget you are trying to change, and find the targets with the most connections.

4. **Influencers:** See who you know and influential they are—and how much you think you can influence them.
Proceed to Step Two to analyze targets. Analysis will help you both choose the best targets and better understand how they can be reached and influenced.

### Step Two: Choosing a Primary Target

<table>
<thead>
<tr>
<th>Checklist Criteria</th>
<th>Target Option #1</th>
<th>Target Option #2</th>
<th>Target Option #3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge of the Issue (high, medium, low)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do they support your objective? (yes, no, maybe)</td>
<td></td>
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<tr>
<td>Accessibility—</td>
<td></td>
<td></td>
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<tr>
<td>• Are they vulnerable?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>• Could they switch sides?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Are they dead set in their position?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Could you neutralize their opposition?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What issues do they care about?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What information or arguments have moved them are they most likely to be moved by?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can you influence them?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Do they know your organization?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Do they respond to your constituency?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Do you have influence in their district/region?</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Do they belong to the party in power or hold high rank?</td>
<td></td>
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</tr>
<tr>
<td>• What are some of their personal affiliations (religious, social, professional)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Do you have connections there you could use?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Who influences them (secondary targets?)—and do you have power with them?</td>
<td></td>
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</tr>
</tbody>
</table>
Conducting Advocacy-Focused Research

Research, when conducted with the purpose of influencing policy, can be a very effective advocacy tactic. Advocacy-focused research is different than academic research, as its purpose is to directly influence policy change and policy decision-making.

Several factors promote strong, effective advocacy-focused research and should be discussed at your organization before research begins so that you can proceed most strategically. Research is often most effective when:

- The information needs of the policy maker are taken into account when designing the study.
- Research is conducted by an organization that policy makers perceive as credible and reliable.
- Research is focused on a few questions that can be answered.
- Findings are presented in multiple formats, tailored to each audience.
- Findings are disseminated to multiple audiences using a variety of channels.
- Audiences receive the same message from diverse sources.
- Presentations of findings to policy makers emphasize the important lessons that were learned, rather than the need for more research.

<table>
<thead>
<tr>
<th>Research can be used to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Choose an advocacy goal;</td>
</tr>
<tr>
<td>2. Support an existing advocacy position;</td>
</tr>
<tr>
<td>3. Determine what is considered changeable or doable in a policy process;</td>
</tr>
<tr>
<td>4. Directly influence decision makers (the primary audience of an advocacy program);</td>
</tr>
<tr>
<td>5. Inform the media, public or others who influence decision makers;</td>
</tr>
<tr>
<td>6. Counter oppositional positions or arguments;</td>
</tr>
<tr>
<td>7. Alter the perceptions about an issue or problem;</td>
</tr>
<tr>
<td>8. Challenge myths and assumptions;</td>
</tr>
<tr>
<td>9. Confirm policy actions and programs that work;</td>
</tr>
<tr>
<td>10. Reconsider strategies that are not working.</td>
</tr>
<tr>
<td>11. Increase efficiency</td>
</tr>
<tr>
<td>12. Avoid embarrassing or politically damaging mistakes</td>
</tr>
<tr>
<td>13. Help target effort and resources most effectively</td>
</tr>
<tr>
<td>14. Structure the most effective solutions</td>
</tr>
<tr>
<td>15. Build new allegiances through research, interviews and networking</td>
</tr>
<tr>
<td>16. Build the credibility of your organization and campaign</td>
</tr>
</tbody>
</table>
Evaluation Resources

The following table lists potential “outcomes” for advocacy and policy work, and the strategies that could be used to achieve these outcomes. This is a tool that you can use to identify potential outcomes of your advocacy campaign as you begin planning, as well as whether or not you’ve achieved these outcomes during your campaign evaluation.

<table>
<thead>
<tr>
<th>Menu of Outcomes for Advocacy and Policy Work</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Shift in Social Norms</strong></td>
</tr>
<tr>
<td><strong>Examples of outcomes</strong></td>
</tr>
<tr>
<td>• Changes in awareness</td>
</tr>
<tr>
<td>• Increased agreement about the definition of a problem (e.g. common language)</td>
</tr>
<tr>
<td>• Changes in beliefs</td>
</tr>
<tr>
<td>• Changes in attitudes</td>
</tr>
<tr>
<td>• Changes in values</td>
</tr>
<tr>
<td>• Changes in the salience of an issue</td>
</tr>
<tr>
<td>• Increased alignment of campaign goal with core societal values</td>
</tr>
<tr>
<td>• Changes in public behavior</td>
</tr>
<tr>
<td><strong>Examples of strategies</strong></td>
</tr>
<tr>
<td>• Framing issues</td>
</tr>
<tr>
<td>• Media campaign</td>
</tr>
<tr>
<td>• Message development (e.g. defining the problem, framing, naming)</td>
</tr>
<tr>
<td>• Development of trusted messengers and champions</td>
</tr>
<tr>
<td><strong>2. Strengthened Organizational Capacity</strong></td>
</tr>
<tr>
<td><strong>Examples of outcomes</strong></td>
</tr>
<tr>
<td>• Improved management of organization capacity of organizations involved with advocacy and policy work</td>
</tr>
<tr>
<td>• Improved strategic abilities of organizations involved with advocacy and policy work</td>
</tr>
<tr>
<td>• Improved capacity to communicate and promote advocacy messages of organizations involved with advocacy and policy work</td>
</tr>
<tr>
<td>• Improved stability of organizations involved with advocacy and policy work</td>
</tr>
<tr>
<td><strong>Examples of strategies</strong></td>
</tr>
<tr>
<td>• Changes in awareness</td>
</tr>
<tr>
<td>• Leadership development</td>
</tr>
<tr>
<td>• Organizational capacity building</td>
</tr>
<tr>
<td>• Communication skill building</td>
</tr>
<tr>
<td>• Strategic planning</td>
</tr>
<tr>
<td><strong>3. Strengthened Alliances</strong></td>
</tr>
<tr>
<td><strong>Examples of outcomes</strong></td>
</tr>
<tr>
<td>• Increased number of partners supporting an issues</td>
</tr>
<tr>
<td>• Increased level of collaboration (e.g. coordination)</td>
</tr>
<tr>
<td>• Improved alignment of partnership efforts (e.g. shared priorities, shared goals, common accountability system)</td>
</tr>
<tr>
<td>• Strategic alliances with important partners (e.g. stronger or more powerful relationships and alliances)</td>
</tr>
<tr>
<td>• Increased ability of coalitions working towards policy change to identify policy change process (e.g. venue of policy change, steps of policy change based on strong understanding of the issue)</td>
</tr>
</tbody>
</table>
Examples of strategies
- Partnership development
- Coalition development
- Cross-sector campaigns
- Join campaigns
- Building alliances among unlikely allies

4. Strengthened Base of Support

Examples of outcomes
- Increased public involvement in an issue
- Increased level of actions taken by champions of an issue
- Increased breadth of partners supporting an issue (e.g. number of “unlikely allies” supporting an issue)
- Increased media coverage (e.g. quantity, prioritization, extent of coverage, variety of media “beats,” message echoing)
- Increased awareness of campaign principles and messages among selected groups (e.g. policymakers, general public, opinion leaders)
- Increased visibility of the campaign message (e.g. engagement in debate, presence of campaign message in the media)
- Changes in public will

Examples of strategies
- Community organization
- Media campaign
- Outreach
- Public/grassroots engagement campaign
- Voter registration campaign
- Coalition development
- Development of trusted messengers and champions
- Policy analysis and debate
- Policy impact statements

5. Improved Policies

Examples of outcomes
- Policy development
- Policy adoption (e.g. ordinance, ballot measure, legislation, legally binding agreements)
- Policy implementation (e.g. equity, adequate funding, other resources for implementing policy)
- Policy enforcement (e.g. holding the line on bedrock legislation)

Examples of strategies
- Scientific research
- Development of “white papers”
- Development of policy proposals
- Pilots/demonstration programs
- Educational briefings of legislators
- Watchdog function

6. Changes in Impact

Examples of outcomes
- Improved social and physical conditions (e.g. poverty, habitat diversity, health, equality, democracy)

Examples of strategies
- Combination of direct service and systems-changing strategies

Framework for understanding the possible outcomes and impact of your advocacy

The following table outlines the difference between intermediate and longer-term objectives for advocacy groups.

<table>
<thead>
<tr>
<th>Dimension of work</th>
<th>Intermediate objectives</th>
<th>Longer-term objectives</th>
</tr>
</thead>
</table>
| **1. Policy change** | • Increased dialogue on an issue  
• Raised profile of issue  
• Changed opinion (whose?)  
• Changed rhetoric (in public/private)  
• Change in written publications | • Changed policy  
• Change in legislation  
• Change in resource allocation  
• Policy/legislation change implemented (and in the very long term)  
• Positive change in people’s lives as a result of the policy/legislation change |
| **2. Strengthening civil society by working with individual organizations and networks** | • Change in individual members’ skills, capacity, knowledge and effectiveness  
• Change in individual civil groups’ capacity, organizational skills, effectiveness  
• Greater synergy of aims/activities in networks/movements  
• Change in collaboration, trust or unity of civil society groups | • Increased effectiveness of civil society work  
• Civil groups active in influencing decision makers in ways that will benefit poor people  
• Civil groups monitoring implementation of policies/programs  
• Partnerships and networks effective and sustainable |
| **3. Support people-centered policy making** | • Greater awareness of individual rights and systems that withhold rights  
• Change in local people’s skills, capacity, and knowledge to mobilize and advocate on their own behalf  
• Increased reporting of rights violations  
• Existence of systems to monitor rights  
• Claims made by CBOs for enforcing rights | • Improved access to basic rights such as health, housing, water, food, non-discrimination |
| **4. Enlarging democratic space or the space in which civil society groups can effectively operate in society** | • Greater freedom of expression  
• Greater acceptance/recognition of civil groups  
• Existence of fora for civil groups to input into a wider range of decisions  
• Increased legitimacy of civil society groups | • Increased participation of civil society groups in influencing decisions  
• Change in accountability and transparency of public institutions |

From "Monitoring and Evaluating Advocacy," Jennifer Chapman, Action AID UK.
### Overview of Methods to Collect Information

The following table provides an overview of the major methods used for collecting data during evaluations.

<table>
<thead>
<tr>
<th>Method</th>
<th>Overall Purpose</th>
<th>Advantages</th>
<th>Challenges</th>
</tr>
</thead>
</table>
| Questionnaires, surveys, and  | To get quickly and/or easily lots of information from people in a non threatening | - Can complete anonymously  
| checklists                     |  way                                                                   | - Inexpensive to administer  
|                               |                                                                   | - Easy to compare and analyze  
|                               |                                                                   | - Administer to many people  
|                               |                                                                   | - Can get lots of data  
|                               |                                                                   | - Many sample questionnaires already exist  
|                               |                                                                   | - Might not get careful feedback  
|                               |                                                                   | - Wording can bias client’s responses  
|                               |                                                                   | - Are impersonal  
|                               |                                                                   | - In surveys, may need sampling expert  
|                               |                                                                   | - Doesn’t get full story  
| Interviews                    | To understand fully someone’s impressions or experiences, or learn more about their answers to questionnaires | - Get full range and depth of information  
|                               |                                                                   | - Develops relationship with client  
|                               |                                                                   | - Can be flexible with client  
|                               |                                                                   | - Can take much time  
|                               |                                                                   | - Can be hard to analyze and compare  
|                               |                                                                   | - Can be costly  
|                               |                                                                   | - Interviewer can bias client’s responses  
| Documentation review          | To gain an impression of how program operates without interrupting the program; is from review of applications, finances, memos, minutes, etc.   | - Get comprehensive and historical information  
|                               |                                                                   | - Doesn't interrupt program or client’s routine in program  
|                               |                                                                   | - Information already exists  
|                               |                                                                   | - Few biases about information  
|                               |                                                                   | - Often takes much time  
|                               |                                                                   | - Info may be incomplete  
|                               |                                                                   | - Need to be quite clear about what looking for  
|                               |                                                                   | - Not flexible means to get data; data restricted to what already exists  
| Observation                   | To gather accurate information about how a program actually operates, particularly about processes | - View operations of a program as they are actually occurring  
|                               |                                                                   | - Can adapt to events as they occur  
|                               |                                                                   | - Can be difficult to interpret seen behaviors  
|                               |                                                                   | - Can be complex to categorize observations  
|                               |                                                                   | - Can influence behaviors of program participants  
|                               |                                                                   | - Can be expensive  
| focus groups                  | To explore a topic in depth through group discussion, e.g., about reactions to an experience or suggestion, understanding common complaints, etc.; useful in evaluation and marketing | - Quickly and reliably get common impressions  
|                               |                                                                   | - Can be efficient way to get much range and depth of information in short time  
|                               |                                                                   | - Can convey key information about programs  
|                               |                                                                   | - Can be hard to analyze responses  
|                               |                                                                   | - Need good facilitator for safety and closure  
|                               |                                                                   | - Difficult to schedule 6-8 people together  
| Case studies                  | To understand fully or depict client’s experiences in a program, and conduct comprehensive examination through cross comparison of cases | - Fully depicts client’s experience in program input, process and results  
|                               |                                                                   | - Powerful means to portray program to outsiders  
|                               |                                                                   | - Usually quite time consuming to collect, organize and describe  
|                               |                                                                   | - Represents depth of information, rather than breadth  

Contents of an Evaluation Plan

Develop an evaluation plan to ensure your program evaluations are carried out efficiently in the future. Note that bankers or funders may want or benefit from a copy of this plan.

Ensure your evaluation plan is documented so you can regularly and efficiently carry out your evaluation activities. Record enough information in the plan so that someone outside of the organization can understand what you’re evaluating and how. Consider the following format for your report:

1. **Title Page** (name of the organization that is being, or has a product/service/program that is being, evaluated; date)
2. **Table of Contents**
3. **Executive Summary** (one-page, concise overview of findings and recommendations)
4. **Purpose of the Report** (what type of evaluation(s) was conducted, what decisions are being aided by the findings of the evaluation, who is making the decision, etc.)
5. **Background about Organization and Product/Service/Program that is being evaluated**
   a) **Organization Description/History**
   b) **Product/Service/Program Description** (that is being evaluated)
      i) **Problem Statement** (in the case of nonprofits, description of the community need that is being met by the product/service/program)
      ii) **Overall Goal(s) of Product/Service/Program**
      iii) **Outcomes** (or client/customer impacts) and **Performance Measures** (that can be measured as indicators toward the outcomes)
      iv) **Activities/Technologies of the Product/Service/Program** (general description of how the product/service/program is developed and delivered)
      v) **Staffing** (description of the number of personnel and roles in the organization that are relevant to developing and delivering the product/service/program)
6. **Overall Evaluation Goals** (e.g., what questions are being answered by the evaluation)
7. **Methodology**
   a) **Types of data/information that were collected**
   b) **How data/information were collected** (what instruments were used, etc.)
   c) **How data/information were analyzed**
   d) **Limitations of the evaluation** (e.g., cautions about findings/conclusions and how to use the findings/conclusions, etc.)
8. **Interpretations and Conclusions** (from analysis of the data/information)
9. **Recommendations** (regarding the decisions that must be made about the product/service/program)
10. **Appendices:** content of the appendices depends on the goals of the evaluation report, e.g:
    a) **Instruments used to collect data/information**
    b) **Data**, e.g., in tabular format, etc.
    c) **Testimonials, comments made by users of the product/service/program**
    d) **Case studies of users of the product/service/program**
    e) **Any related literature**

Using Human Rights to Influence Policymakers

Human Rights Form a Basis for Demands for Better Health Care

The government’s human rights obligations can be used to justify a demand. Why should the government provide essential medicines or ensure that health services are accessible to all? One reason is that the government has a legal obligation to do so. Using human rights in this context may be especially useful if the government takes a position contrary to human rights. Examples of human rights forming a basis for demands:

- Human rights law requires gender equity. Are there aspects of Uganda’s legal code that violate women’s rights?
- National health plans must contain right to health indicators whose progress can be closely monitored and reviewed periodically “on the basis of a participatory and transparent process.” Is the government being transparent about progress?
- Government must do more than adopt health strategies; it must implement them. Are good plans not being implemented?
- Human rights require equitable distribution of health facilities, goods, and services. Is the distribution unequal?
- If the government is not meeting its obligations, you have the right to DEMAND CHANGE!

Human Rights are a Lens to See Underlying Causes

Human rights can be a mode of thinking that gets health workers and community members asking: “Why?” Why are so many children malnourished or suffering from diarrhea? Why does the clinic have no medicine? Rather than simply treating malnourished child after malnourished child, or sending sick patients away with no medicine, health workers and community members who are thinking about human rights will look to the underlying causes. The health worker will not passively accept that the clinic is constantly short of medicine, but will ask “Why?” Is there too little money to buy medicines? A poor drug distribution system? Corruption? The health worker will also act – perhaps, calling, writing to, and meeting with local health ministry officials, and working with colleagues and the community – to solve the immediate problem, and get the medicines to the clinic.

Human Rights Can be Used to Analyze Existing and Proposed Policies

Human rights criteria can be used to analyze and propose changes to existing or proposed policies. Examples: While there is no one right way to scale-up treatment, an approach consistent with human rights must include a strategy to reach marginalized and other hard-to-reach populations. Does Uganda’s ARV scale-up plan include special efforts to reach marginalized and other hard-to-reach populations? Do Uganda’s laws provide full equal rights for women, or are they discriminatory in any way? Does Uganda have laws and policies that protect the safety of health workers?

Human Rights Can Guide Formation of New Policies

You can look to human rights to determine what elements should be included in new laws and policies. For example: WHO’s guidance on equity and ethics in scaling up access to AIDS treatment and care is informed by such human rights principles as protection of marginalized populations and community participation in decision-making. A new Ugandan policy on human resources for health should be guided by human rights demands of equitable distribution of health services, as well as the need to ensure that health services (and so health personnel) are available in sufficient quality.
Human Rights Give Power to the People
Socially disadvantaged, poor, and other marginalized populations -- or indeed, anyone, such as a health worker -- may feel that they have little hope of influencing government action, that all the power is in the hands of the government, which will do as it pleases. Educating people about their rights can provide a new sense of power, and a belief that they can make demands of the government, and the government must listen. The government cannot do whatever it pleases; it must respect, protect, and fulfill their rights.

Human Rights Can Build a Consensus
Some issues are controversial. If all sides respect human rights, they may be able to find common ground. For example, the proportion of HIV infections caused by unsafe injections has been the subject of much controversy, but even those who think that only a very small proportion of HIV infections are caused by unsafe injections can agree: Everyone has the right to safe health care.

Human Rights Can Provide Added Legitimacy
Human rights can help transform the discussion on several key needs of the Ugandan health sector. When health workers insist on higher pay, or gloves and other gear and devices to protect themselves, some people might view these demands as self-interested, if understandable. Emphasizing that these demands are based on human rights may help build support. For example, the Economic, Social and Cultural Rights Committee’s General Comment 14 states that health personnel have a right to “domestically competitive salaries” and states are required to “to provide a coherent national policy on occupational safety and health services.”

Human Rights Can Provide a Measuring Stick for Progress
Do you want to know whether the government making adequate progress on such issues as AIDS care and treatment, reducing maternal mortality, and increasing child survival? First ask: Does the government have a strategy? Does the strategy have benchmarks that can be used to measure progress? Does the strategy incorporate all relevant aspects of the right to health and other rights? Next ask: How is the government implementing the strategy? Is it meeting its targets? Is the government implementing all elements in the strategy related to human rights? Finally ask: Are the targets themselves adequate? It might not be enough for the government to achieve its goals. State-determined goals are consistent with human rights only if they meet certain requirements. These include the state’s obligation to put “the maximum of its available resources” towards the full realization of the right to health and other human rights, and to move towards that full realization “as expeditiously and effectively as possible.” If the government fails to do so, it is not fulfilling its human rights obligations, even if it is meeting its stated goals.

Human Rights Violations May Find a Remedy in Court
Human rights violations necessarily break the law. Courts may therefore be able to provide a remedy. (Though courts in Uganda are not particularly strong, and access to legal assistance limited.) In theory, courts should be open to a wide range of claims, including violations of international law. In practice, without domestic legislation implementing international legal standards, courts will be most useful for violations of domestic law. For example, if you learn that a patient has suffered discrimination (e.g., fired from her job because she was HIV-positive), you should refer her to a legal aid organization, like the Association of Uganda Women Lawyers (FIDA) or Raising Voices (in Kampala).

Human Rights Can Help Add Partners
The many intersections between health and human rights, including the right to health itself, can help many different groups -- such as health workers, women’s rights advocates, advocates for the poor, human rights NGOs, and lawyers -- see their common agenda, and recognize that by communicating and forming formal or informal partnerships, everyone’s work may be strengthened. For example, health workers, women’s rights advocates, advocates for the poor, rural development NGOs, and community-based organizations all would have a role to play in determining how to ensure that residents of rural areas, including women, have access to effective health services. There may be human rights organizations that might not have thought of health as a human rights issue, but would be interested in working on right to health issues if they recognize that health is all about human rights.
**Human Rights May be a Catalyst for Domestic and International Pressure**
Most governments care about their public image. While they may violate human rights, few governments like to be seen as human rights violators. Therefore, exposing human rights violations, and possibly creating national or even international public outcry, can help bring an end to the violations. Because Uganda enjoys a very good international reputation, Uganda’s government may have a particularly strong interest in responding to international pressure so that Uganda’s good international reputation is not tarnished. Potential targets for advocacy may include donors who can pressure the government to conform with its human rights obligations (e.g., US Ambassador).

**Human Rights Can Force a Government to Pay Attention**
Government may want to ignore certain issues, perhaps because they are expensive or culturally difficult to address, or politically unpopular. Yet government may have human rights obligations to address these issues. In the face of people demanding their rights, the government may have to provide an answer. A prime example is the issue of AIDS treatment, which was long dismissed as too expensive and difficult to administer in Africa. But people in Africa began to demand their right to treatment, and now their governments and the international community have begun to meet that demand.

**Human Rights Can Give You Confidence**
Afraid about approaching a superior at work or an important politician? Remember: You are in the right when you demand that government lives up to its human rights obligations. You are simply asking that government do what it has committed itself to do. So go ahead and demand that your rights – and your patients’ and your communities’ rights – be fulfilled!
The Health Workforce Advocacy Initiative (HWAI) includes information on HWAI, including materials and how to get involved: http://www.healthworkforce.info/HWAI/Welcome.html

The Global Health Workforce Alliance (GHWA) website includes information about GHWA, the Global Action Plan on Human Resources for Health, and other health workforce material that may be useful: http://www.ghwa.org

World Health Organization, World Health Report 2006: Working Together for Health (2006). Available at: http://www.who.int/whr/2006. This report is a major WHO publication outlining what needs to be done to strengthen the health workforce. The appendix includes key statistics including on the number of health care workers and on health spending in different countries. Additional health workforce information from WHO is available at: http://www.who.int/hrh

A Physicians for Human Rights guide to ensuring that human rights informs the human resources for health planning process is available through at: http://physiciansforhumanrights.org/library/report-2008-02-01.html


The Capacity Project is publishing a series of case studies as part of their Health Workforce “Innovative Approaches and Promising Practices” Study. These will cover promising practices in Ghana, Malawi, Namibia, and Uganda, and are available at: http://www.capacityproject.org/index.php?option=com_content&task=view&Id=164&Itemid=158

The World Health Organization and several partners have developed an HRH Action Framework to assist with health workforce planning, available at: http://www.capacityproject.org/framework/. The Framework links to a number of
human resources for health tools. Some human resources for health tools can also be accessed at 
http://www.who.int/hrh/tools/. A smaller set of tools that have been reviewed by people with expertise in human 
resources for health can be found at the HRH Tools Compendium, available at: http://www.hrhcompendium.com/.

The HRH Global Resource Center is a “digital library devoted to human resources for health (HRH),” and is available at: 
http://www.hrhresourcecenter.org/

EQUINET has an extensive set of publications on the health workforce and other issues pertaining to health and equity in Africa though their website: http://www.equinetafrica.org/

An open access (free) journal on Human Resources for Health is available at: http://www.human-resources-
health.com

The Manager’s Electronic Resource Center, which contains a wide range of tools for health managers in such areas as human resources for health, leadership, finances, information, managing drug supplies, community health services, health systems reforms, and organizational management, is available at: http://erc.msh.org/

The Eldis Health Systems Resource Guide, which contains an extensive set of resources on human resources for health and other health system issues, is available at: http://www.eldis.org/healthsystems/index.htm
Mounting evidence in recent years suggests that the economic policies promoted and enforced by the International Monetary Fund (IMF) may be preventing developing countries from being able to spend more in their national budgets, with important consequences for health and education budgets being constrained at unnecessarily low levels at a time when major increases are needed.

According to the World Health Organization (WHO), 57 countries, most of them in Africa and Asia, face a severe health workforce crisis. WHO estimates that at least 2.4 million health professionals and 1.9 million health workers, or a total of 4.3 million health workers, are needed to fill the gap. Without prompt action, the shortage will worsen. Health workers are inequitably distributed throughout the world, with severe imbalances between developed and developing countries. This global workforce shortage is made even worse by imbalances within countries, with the greatest deficits in peri-urban and rural areas, and with misallocations between public and private/NGO/faith-based sectors. Sub-Saharan Africa faces the greatest challenges: while it has 11 percent of the world’s population and 24 percent of the global burden of disease, it has only 3 percent of the world’s health workers.

Regarding the global shortage of professionally-trained school teachers, UNESCO’s Institute of Statistics estimated in 2006 that globally, to get all children into school in class sizes of under 40 pupils, 18 million new teachers will be required. Sub-Saharan Africa alone will require a 68% increase in primary school teachers, from 2.3 million to 4 million to meet this pupil teacher ratio. Meeting the 40 to 1 teacher-pupil ratio is important because a larger class size negatively impacts the quality of education.

These additional doctors, nurses and teachers cannot be hired under unnecessarily restrictive fiscal policies (deficit-reduction targets) and monetary policies (inflation-reduction targets) attached as binding conditions on International Monetary Fund loan programs.

The Importance of the IMF

The IMF was created in the 1940s after World War II to help finance the rebuilding of Europe and to provide short-term loans to countries that were importing more than they were exporting. However, in the 1980s, the Reagan administration in the US and the Thatcher government in the UK led a sea change in the way economics is understood, and introduced a whole new set of free market and “free trade” policies into the international foreign aid system by attaching such economic policy changes as conditions on foreign aid to developing countries. At the IMF in particular, part of this major change was the introduction of “monetarist” policies, which prioritized extremely low inflation and reducing or eliminating government deficits over other goals such as higher employment, GDP growth and public investment. While these policies were ostensibly designed to force governments into tackling the huge debt crisis and macroeconomic instability afflicting many developing countries at the time, today these policies are undermining the ability of poor countries to scale-up public spending to fight HIV/AIDS and other pressing health needs and to achieve the Millennium Development Goals (MDGs) for health and education.

The immediate consequences of the IMF policies in the 1980s and 1990s were steep layoffs of personnel across all the public sectors, including public health systems. The lasting impacts have prevented countries from being able to make the necessary long-term capital investments in the underlying infrastructure of the public health systems. Public investment as a percent of GDP has been chronically under-funded in many countries over many years, leading to dilapidated public health facilities, weakened health systems, and an insufficient number of health workers across the developing world today. The IMF’s restrictive spending policies prevent countries both from being able to absorb and spend more foreign aid and from generating more of their own resources domestically.
The IMF’s “Signal Effect” to Other Aid Donors

Over these years, the IMF has amassed tremendous power for itself as the final arbiter of what supposedly constitutes appropriate policies for “macroeconomic stability,” and as a consequence, most bilateral and multilateral lenders and aid donors look to the IMF for its “red light/green light” signal before giving foreign aid, loans or debt cancellation to developing countries. In this way, the IMF has come to play the role of the head of a foreign aid cartel, in which most other foreign aid donors have abdicated their own individual ability to assess the economic policies of their borrowers. Although the UK has suggested it will not only look to the IMF signal before giving bilateral aid, its representative to the IMF Executive Board still supports IMF policies.

Moreover, the officials in many finance ministries in developing countries have been trained in the same economic theories as those promoted by the IMF, and ascribe to the same policies that emphasize low inflation and low deficits over the higher levels of public investment needed for a healthy and educated population to generate sustained economic growth and shared prosperity.

The IMF’s Policies Are Unnecessarily Restrictive

A research report by the US Congress explained there is a “substantial gray area” between those fiscal and monetary policies that may be considered too austere, resulting in economic stagnation, and those that cause macroeconomic instability. And while no one wants policies that are too loose and can lead to overspending, hyperinflation and instability, the report warned, “Policies that are overly concerned with macroeconomic stability may turn out to be too austere, lowering economic growth from its optimal level and impeding progress on poverty reduction.”

Presumably, one goal of including the macroeconomic framework within the national dialogue with NGOs for drafting Poverty Reduction Strategy Papers (PRSPs) was to allow other policy options within this “gray area” to be fully explored to establish an effective mix of pro-growth and pro-health policies consistent with the medium-term goals of the country. However, this has not been the case. Not only is there mounting evidence in the empirical economics literature that the IMF’s policies sit at the austere end of the gray area, but such policy decisions have never been opened to NGOs or broader public stakeholders. Usually the IMF staff set such policies with finance ministry officials behind closed doors.

A 2007 study that examined at the impact of IMF policies on health spending in low-income countries, led by the Washington-based Center for Global Development, found that, “The evidence suggests that IMF-supported fiscal programs have often been too conservative or risk-averse. In particular, the IMF has not done enough to explore more expansionary, but still feasible, options for higher public spending.” And on monetary policy the report noted, “Empirical evidence does not justify pushing inflation to these levels in low-income countries.” A similar recent study of IMF inflation-reduction policies by the University of Massachusetts, Amherst, found, “There is no justification for inflation-targeting policies as they are currently being practiced throughout the middle- and low-income countries.” And most recently, the House Financial Services Committee of the US Congress weighed in on this issue in a November 2007 letter to the IMF, saying: “We are concerned by the IMF’s adherence to overly-rigid macroeconomic targets” in low-income countries, and, “It is particularly troubling to us that the IMF’s policy positions do not reflect any consensus view among economists on appropriate inflation targets.”
IMF Policies Can Block the Spending of Donor Aid

A 2007 report by the IMF’s Independent Evaluation Office (IEO) on “The IMF and Aid to Sub-Saharan Africa,” examined IMF loan programs to 29 Sub-Saharan African countries between 1999-2005 found that 37 percent of all annual aid increases to these countries in these years was diverted into building international currency reserve levels and that another 37% was devoted to debt repayment. That left and only about $2.70 of every $10 in annual aid increases for actual spending on health, education, infrastructure, or other development needs. So-called weak performers (those with inflation above 5% and “low” foreign currency reserves) on average spent only of 15% of new aid. Having so much of new aid increases not being spent was certainly not the intention of the donors, or citizens in donor countries. According to the IEO report, the “main drivers” in decisions to curtail spending of the aid was the IMF’s insistence on very low levels for inflation, its excessive concerns about the volatility of aid, and its desire for ever higher currency reserves to protect against economic “shocks.”

As part of the larger context for the IMF’s tight monetary policies, one of the major overarching findings of the IEO report was that the IMF Executive Board and senior management were never really enthusiastic about the emphasis placed by donors on “poverty reduction” or the new efforts to scale-up aid and spending for the MDGs over the last several years. Without strong internal leadership directing any real policy changes in this regard, and without wide-spread publicity about pro-spending, pro-growth policy changes, the IEO report found that staff simply reverted to prioritizing macroeconomic stability over other goals. The important implication of this finding for aid advocates is that there is a contradiction happening within the leading donor governments between enabling a “scaling up environment” on the one hand while enforcing rigid macroeconomic stability and spending restraint on the other.

A New York Times editorial appropriately summarized the current contradiction in donor policies: “There is a desperate need for greater policy coherence in a period when many national governments, including Washington, are sensibly exhorting African governments to spend more on primary health care and education while international financial institutions largely controlled by those same Western governments have been pressing African countries to shrink their government payrolls, including teachers and health care workers.”

Wage Bill Ceilings Cause Alarm

In recent years, the IMF felt the need to suppress government spending through the use of so-called “public sector wage bill ceilings,” or caps on the amount of money used for paying the wages of public sector employees. Such wage bill ceilings have interfered with countries’ ability to educate, hire and retain the numbers of doctors, nurses, healthcare workers and teachers needed to fight HIV/AIDS and achieve the MDG health goals or to train younger generations. For example, such a policy in Kenya led to several thousands of professionally trained nurses remaining unemployed over many years. International public pressure forced the IMF into retreating somewhat on its wage bill ceiling policy in July 2007, but the IMF still reserves the right to impose such caps, while promising to do so less often in the future. However, the wage bill ceilings are merely a symptom of the deeper problem arising from unnecessarily restrictive fiscal and monetary policies: chronically insufficient public spending and under-investment in human capital development and preservation.

Debt Relief Is Not Enough

Although the rich countries have provided some debt cancellation under the Heavily-Indebted Poor Countries (HIPC) Initiative and the more recent Multilateral Debt Relief Initiative (MDRI), too little debt cancellation has been made available for too few countries in need. Impoverished countries that have benefited from initial debt cancellation are challenged to make use of the savings because of the continuing restrictive policies that still limit spending. Not only must countries remain “on track” with their IMF programs in order to access debt cancellation, but even afterwards they must continue to comply with IMF policies to access additional donor aid. Concerns about this problem were well exemplified in a recent report on Zambia by the United Nations Development Program’s International Poverty Centre, “Does Debt Relief Increase Fiscal Space in Zambia? The MDG Implications,” which found that even after receiving bilateral and multilateral debt cancellation, Zambia will still not be able to significantly scale-up public spending or investment because of the continuing demands for excessively tight fiscal and monetary policies in its IMF loan arrangements.

“The IMF has not done enough to explore more expansionary, but still feasible, options for higher public spending.” CENTER FOR GLOBAL DEVELOPMENT
Take Action!

1. Demand that the IMF change and widely publicize revised macroeconomic restraint policies

Every time the IMF’s macroeconomic policies are challenged, it responds that “we are addressing that.” The truth is that the IMF has not explicitly repudiated its overly restrictive inflation and deficit targets, nor has it widely publicized new found flexibilities for health and education spending. Not only must the IMF reverse its anti-growth, anti-health, and anti-education policies, it must publicize any new policy flexibilities widely to Ministries of Finance and to its own staff.

2. Demand that other policy options for increased public spending be fully vetted and explored

Health, education and HIV/AIDS advocates should work together with macroeconomists to learn about the current policies to which the IMF and many finance ministries adhere, their harmful impacts on constraining education and health spending, the existence of more expansionary spending policy options, and what such alternative policies could mean for increasing public health and education investments in developing countries. Each of the alternative policy options will have its own short-term and long-term costs and benefits for countries, and advocates should demand that all of these should be fully explored and considered.

3. Demand greater public stakeholder involvement in such explorations of alternative spending options

Health, education and HIV/AIDS advocates should demand that NGOs and other key stakeholders such as the education and health ministry staff, key legislative committee members, labor unions and even the domestic media be allowed to participate in such in-depth explorations of alternative policy options for increased public spending.

4. Call on your Government to raise this issue through the Executive Board of the IMF, which approves the IMF loan programs for borrowing countries

Advocates should insist that the policies first introduced over 20 years ago be revisited and changed to enable countries to meet current health and education imperatives.

Contact Rick.Rowden@actionaid.org for the latest research and analysis on these issues or for information about ActionAid’s Multi-Country Economic Literacy and Advocacy Project (“The IMF Project”), which will include 4 sets of introductory Macroeconomic Literacy Trainings and a series of national advocacy initiatives over 2 years (2008-2009) for health, education, HIV/AIDS and women’s rights advocacy organizations in 4 countries: Kenya, Sierra Leone, Malawi and the United States.

CAPTIONS: Cover and Back right: Mozambique (photographer Jenny Matthews); Inside left: Kenya, Patients waiting at Lugumek dispensary (photographer Liba Taylor); Inside middle: Ethiopia, A community-based outreach health workers shows a range of contraceptives (photographer Jenny Matthews); Inside right: Ethiopia, Nurse Mashresha Legesse giving medical advice to a patient at the Health Post (photographer Liba Taylor); Back left: Ethiopia, Tilahun, one of the community-based outreach health workers telling people about contraception at the weekly market (photographer Jenny Matthews); Back middle: Kenya, Community nurse Leah Mitei giving injection to young child at Lugumek dispensary (photographer Liba Taylor)
References

18. The latest numbers that WHO has available on the number and density of health workers in individual countries can be accessed through its Global Health Atlas at: http://www.who.int/globalatlas/DataQuery/default.asp. WHO’s World Health Report 2006 also
has an annex providing the number and density of health workers in individual countries, available at: http://www.who.int/whr/2006/annex/06_annex4_en.pdf.

23 The proportion of budgets spent on health as of 2004 is available in this Excel spreadsheet: http://www.who.int/nha/country/Annex162.%20March%202005.%202007.xls. The proportion may have increased or decreased since that time.

24 Information on Millennium Challenge Corporation is available at: http://www.mca.gov/

25 Individual country information about successful Global Fund applications (including copies of the proposals) and members of your country’s Country Coordinating Mechanism are available through the Global Fund’s website: http://www.theglobalfund.org/


27 Content from this section came from the Advocates for Youth Website at http://www.advocatesforyouth.org/PUBLICATIONS/advocate/chapter9.htm.